Scientific Persuasions

ETHNOGRAPHIC REFLECTIONS ON EVIDENCE-BASED PSYCHOLOGICAL THERAPY

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Declaration:

This thesis is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text.

It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. I further state that no substantial part of my dissertation has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text.

It does not exceed the prescribed word limit for the relevant Degree Committee.

abstract

Title: Scientific Persuasions: ethnographic reflections on evidence-based psychological therapy

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This thesis seeks to encourage an anthropology of psychology through an ethnographic account of evidence-based psychological therapy in the United Kingdom. It examines the 'Improving Access to Psychological Therapies' (IAPT) service established in 2008 as part of the National Health Service (NHS) and is based on 18 months of fieldwork conducted between 2016 and 2018 amongst mental health professionals and therapists-in-training. Through the invention of IAPT, 'Cognitive Behavioural Therapy' (CBT) and other cognate therapies such as 'Mindfulness' have become a hallmark of 'evidence-based' psychological healthcare. This research takes up the question of their acclaimed scientific status and asks how, and with what effects, psychological therapies have become conceivable and workable within the framework of evidence-based medicine (EBM).

Divided into six chapters, the thesis offers a series of ethnographic reflections on some of the effects of the institutionalisation of evidence-based psychological therapy and the scientific persuasions that have made it possible. This research thus investigates the principles underlying psychological therapy, how they are conveyed through training and conferences, and how practitioners make sense of them in their everyday work. It examines some of the histories and logics that underscore the invention of IAPT, how psychological therapies align with dominant discourses in biomedicine concerning treatment and evidence, and some of the assumptions concerning ideas of selfhood that are implicit in them. We will see how professionals acquire particular skills and sensitivities in order to become therapists, how within specific professional contexts they debate and disagree with each other, yet also how they produce certain forms of critique and contextualisation familiar to social scientists. The ethnography shows that whilst psychological therapies – from 'CBT' to 'Mindfulness' – have become recognised as effective interventions for a range of mental health problems, they have also generated their own empirical tensions and uncertainties. We follow these ethnographic realities as we move from some of the ambitions and problems of the IAPT service to the contexts of research, education and training of therapists.

The thesis argues that the epistemic success of CBT as the benchmark model of psychological healthcare in the UK rests on a persuasive, recursive move: CBT introduces

accountability and measurement at the heart of its proposed vision of mental health – enacted through particular therapeutic practices of self-reporting and self-inspection – and this in turn enables it to demonstrate its value and validity in the terms set by the conventions of 'evidence-based' practice. As a result, psychotherapeutic care has been reconstituted as a highly manualised, standardised and quantifiable intervention. It is the quest for objectivity and scientific validation that requires psychological therapy to be enacted as an object of scientific testing and accountability by way of rendering the human subjecthood at the core of its practice amenable to measurement and intervention. Such an ambition is not new in psychology, as we shall see, but it has been revivified in new and interesting ways through the promises and persuasions of evidence-based psychological therapy.

The thesis thus contributes to anthropological studies of scientific epistemologies and therapeutic practices and suggests a way of treating ethnographically common psychological realities, including those found in the conceptual worlds of anthropologists.

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contents

acknowledgements

I wish to thank all the mental health professionals, members of staff, and the residents I worked with at the South London Community Centre, as well as the CBT therapists and students I met at the university in Northern England. They all took a keen interest in my research for which I am grateful; I hope that I have done justice to at least some of their many insights and some of the complexity of their professional world.

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Denne afhandling er dedikeret til min mormor.

notes on the text

For the sake of anonymity, all the names of people encountered during my fieldwork have been replaced by pseudonyms with the exception of public figures, such as clinical psychologist David M. Clark and economist Richard Layard, and other published advocates and commentators cited in the text. Obvious identifying details of the university and community centre featuring in the text have been omitted in order to maintain the anonymity of staff, students, volunteers and others I worked with. It should also be noted that the 'service users' and 'patients' referred to in the text were encountered in social contexts outside of the National Health Service (NHS); I did not conduct research inside the NHS nor with NHS patients. Written or oral consent from participants was obtained wherever it was deemed appropriate and needed. This research project has followed the ethical guidelines of the Association of Social Anthropologists in the UK and Commonwealth (ASA) and received clearance from the PhD Committee of the Department of Social Anthropology in June 2016.

Some of the quotations in this thesis are based on recorded conversations and some of them have been edited slightly in a way that preserves both coherence and clarity; readers read them not as spoken language but as texts, and the rules of those two modes of expression differ: it is not my intention to make people seem less fluent than they appear in person, and to quote verbatim without any editing would have done exactly that.

The text in this thesis is set in 12-point Minion Pro font, with chapter titles and headings in 28-point and 14-point Gill Sans Nova font, and subheadings in 12-point Gill Sans MT font. Extended quotations are indented in the body of the text and set in 11-point Minion Pro font.

introduction

Psychology has increasingly come to occupy a central position in British mental healthcare. With the institutionalisation of evidence-based medicine (EBM) from the 1990s onwards, the scientific evidence base of psychological therapy has come under scrutiny. 'Evidence-based psychological therapy' is now deemed important in the provision of mental healthcare in the UK.

This thesis draws on fieldwork with mental health professionals and therapists-in-training. It is an anthropological study of Cognitive Behavioural Therapy (CBT), with reference also to Mindfulness-Based Cognitive Therapy (MBCT) or 'mindfulness', in the institutionalised form it has taken as part of the National Health Service (NHS) programme called *Improving Access to Psychological Therapies*, commonly referred to by its acronym 'IAPT',[1] launched in 2008. We are dealing here, therefore, with some recent developments in British mental healthcare.

The thesis is divided into six chapters. The first chapter takes us straight into the professional world of IAPT therapists in the context of a South London community where the IAPT service has recently been introduced. The second chapter offers an historical interlude as we follow some key historiographical moments in the histories of psychology and psychotherapy before arriving at the invention of the IAPT programme. The third chapter takes us further into the circumstances of IAPT; it describes some common critiques of psychological therapy and examines the ethnographic and analytical significance of such critiques. In the fourth chapter, we move from the IAPT service to the training of IAPT therapists and explore what it means to learn to work therapeutically according to the model of CBT. The fifth chapter invites us to the conferences in which evidence-based therapy is discussed amongst professionals, and in which a 'real science' of psychotherapy is self-consciously pursued and defined. In the sixth and final chapter, we arrive in the therapeutic practice of psychological therapy: CBT meets mindfulness here, and we find our selves hovering between different models of the mind. We end with some reflections on 'reflective thought'.

We are thus examining evidence-based psychological therapy through some aspects of professionals' daily work, as well as through the training, conferences and courses that make it possible; in following this, we will be watching the pursuit of scientific status in the context of

[1] Pronounced 'ʌɪˈapt'.

some of the histories and theories of psychotherapeutics more generally. We are in the world of mental healthcare and the scientific persuasions of psychology.

Fieldwork

Situating the thesis: some contexts and concerns

This thesis is the result of several years of fieldwork carried out in contexts where 'mental healthcare' is sought and practised. The research for this thesis is in part a continuation of previous projects. My first foray of fieldwork into the field of mental healthcare began in 2012 when I carried out three months of ethnographic research for my undergraduate dissertation at the Department of Social Anthropology, Cambridge. This fieldwork, although necessarily brief, presented an account of clinical psychologists in Denmark and explored some common aspects of their clinical practices. This work examined notions summarised as 'the clinic', 'the client' and 'care' which underpinned the therapeutic concerns and contradictions of this professional world (Bruun 2013). The summer of fieldwork in the clinic that I spent studying for this proved exciting but also tremendously difficult. 'Access' became an issue. No one, it seemed, and especially not the psychologists, wanted the intrusion of an outsider. Access was especially limited because psychotherapy is a practice highly self-aware of its therapeutic space: of the intimate, vulnerable and strictly confidential relation between the clinician and client. There can be no third-party observer in the consultation room. My very presence would collapse the practice I had set out to study. The methodological limitation here marks out the field of psychology and the difficulties of conducting ethnographic research in this area. It also points to a significant ethnographic boundary: in the study of scientific and therapeutic practices, questions of access can carve out 'the field' (Candea 2007).

The recognition of the restrictions imposed on fieldwork 'access' in clinical contexts meant that any follow-up work had to be focussed not on the consultation practice per se but instead on the therapeutic training in some form. I tried this out through research in the UK looking at training in 'play therapy' – a type of psychodynamic child therapy (Bruun 2014). It seemed that the training offered another ethnographic starting point that my first fieldwork in the psychologists' clinic had not so easily allowed.[2]

[2] Negotiating 'access' and 'presence' is not, of course, a unique circumstance of anthropological fieldwork, but more frequently so perhaps for medical anthropologists who often have to deal with critical issues

The fieldwork for this current thesis benefits therefore from the methodological sensibilities gained during earlier ethnographic work where fieldwork presence was often a matter of concern – for the people involved as well as myself, albeit for different reasons.

All fieldwork is, we might say, 'multi-sited' in one sense or another (Falzon 2009). My own research has involved several 'sites' – but all connected by the governance of 'mental healthcare' implicated in the NHS programme of IAPT. My research has involved some moving between different field sites. Shifting between contexts meant shifting between different identities as an ethnographer and adapting various 'insider' and 'outsider' positions that the fieldwork afforded. I shifted between working in a community centre based in London to following a postgraduate degree in CBT at a university in Northern England; in-between these commitments, I travelled from bustling conferences with hundreds of attendants to tranquil therapy sessions with only a small number of participants – each field 'site' demanding its own ethnographic sensitivities. During the university training course in CBT, I participated as a fellow 'student' as far as this was possible.[3] In the South London Community Centre where I lived and volunteered, I was unanimously included as a member of staff, in a volunteering position as a coordinator of a 'wellbeing group'; I was expected to participate alongside other staff members in weekly meetings, training events, and administrative tasks. In between all of this, when attending a range of conferences, I was more or less unproblematically participating as an 'anthropologist'. Finally, I participated in a range of CBT therapy sessions, including two mindfulness courses, offered to 'the public' by local IAPT services.[4]

There are perhaps a couple of important points to address here concerning what tend in the social sciences to be subsumed under two qualifying categories often referred to as 'research ethics' and 'methodology' (with some mode of 'reflexivity' featuring in one of the two).

The first point concerns my own professional stance as an ethnographer. Whilst my fieldwork involved psychotherapeutic training and numerous hours of participation in therapy sessions and courses, I deliberately never sought to qualify as a therapist, nor did I think of

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relating to 'patient confidentiality' and other aspects of clinical 'ethics' as a prerequisite for any kind of ethnographic research (Simpson 2011). On 'negotiated' participant-observation in clinical settings, see Wind (2008).

[3] Although I was often identified – and given a status – as a 'visiting researcher', thus changing my position as a fellow therapist-in-training, see Chapter 4.

[4] Mindfulness-based cognitive therapy or 'MBCT' is the official label for what is often referred colloquially to as simply 'mindfulness' in UK mental healthcare services.

myself as one. I did not, in other words, work as a psychotherapist as part of the fieldwork, nor did I pretend to have the necessary skills required to do so. As a result, I was never required to commit professionally to psychotherapy or any psychotherapeutic school, theoretical or otherwise.

The second point is that I did not attempt to pass as a 'patient' either, as a way of gaining better access, as it were, to psychotherapy (i.e., clinical assessments, therapy sessions and consultations). I do not consider it a necessary condition for fieldwork to assume the role of a patient in order to study psychotherapy; I am making this point explicit here, as many anthropologists suggested me to do so. Such expectations were not unanticipated as medical anthropology has often appeared to assume a richer ethnographic reality surrounding 'patients', with medical anthropologists often writing as if representing the 'patient perspective' or experience. This tendency is perhaps not so surprising either since we know that social anthropology also tended historically to find supposedly denser versions of 'culture' amongst people deemed at the peripheries, geographical or otherwise. For example, even when 'Europe' was finally established as a pertinent area of ethnographic study, anthropologists still travelled to Europe's perceived peripheries to find the 'real people' (on this general point, see Ardener 1987; McDonald 1987; Herzfeld 1989). Similar metaphorical peripheries have had a stronghold of a medical anthropology finding its 'real people' in the category of 'patients' (rather than, say, professionals, policymakers, and administrators). Although patients were necessarily implicated in my fieldwork, I decided to attend and participate in therapy sessions and workshops as a member of 'the public' or in my capacity as a 'researcher'.[5]

The difficulties of access and fieldwork presence in psychotherapeutic contexts – in clinics, institutes, training programmes, therapy sessions, etc. – have been duly noted by a few anthropologists who have previously undertaken research on psychoanalysis (cf. Gellner 1985; Kirsner 1998) and psychodynamic psychotherapy (cf. Luhrmann 2000; Davies 2009). In most cases, fieldwork in psychotherapeutic contexts has been achieved on the basis of the anthropologist's additional professional position as a psychologist, psychotherapist or similar accreditation that allows for an undisputed 'insider' status in disciplinary terms. Ernest Gellner was famously unsuccessful on several occasions in gaining permission to study the British Psychoanalytic Society, turned down by the then President of the Society, Donald Winnicott.

[5] I always identified myself as an anthropologist and stated the purpose of my attendance whenever it was relevant or otherwise required.

The resistance to Gellner's proposal appeared to be largely due to his principal status as an anthropologist and the fact that he had no affiliation to or credibility in the psychoanalytic profession (Gellner 1985). Gellner's position was thus utterly unlike that of Douglas Kirsner's (1998), and later James Davies' (2009), both of whom undertook fieldwork in psychoanalytic institutions in their positions as professional therapists (Kirsner as a clinical psychologist and Davies as a psychoanalytic psychotherapist).

Tanya Luhrmann (2000) also notes the constraints of her fieldwork in her ethnography of American psychiatry, reporting how her father's status as a well-known psychiatrist and eventually her own training in psychoanalysis afforded her access to people and their professional worlds that would otherwise have been unavailable to her. Luhrmann states clearly that her intention was to study and write about psychoanalysts *as an anthropologist*, but it is also clear from her ethnography that her capacity to do so depended at times on taking up and performing the very professional position of the people she studied.

In my own fieldwork, I have not followed the methodological route implicated in the ethnographies cited above. Neither was there any readily available context in which I could simply assume the role of 'the anthropologist' going about doing 'participant observation' in a more or less straightforward way amongst the people and practices I had set out to study. Instead, I found ways to negotiate fieldwork in each context which did not require me to attain or assume a professional commitment akin to the people I studied.

It was through my earlier fieldwork that I had become aware of the notion of 'evidence-based psychological therapy' – a notion that had turned out increasingly to be an issue for the child psychotherapists whose training I had followed; the type of therapy they practised had apparently been unable to achieve an 'evidence-base' within the framework of EBM, thus excluding it from the category of psychotherapies deemed 'empirically supported' by scientific research. I learned soon thereafter that a different practice of psychotherapy called Cognitive Behavioural Therapy or 'CBT' had successfully claimed this label for itself.

This work thus follows on from some of the conclusions of my earlier work by taking up the question of CBT's acclaimed scientific status. It does so not by way of seeking to confirm or deny any claims to scientificity but asks instead how, and with what effects, psychotherapy in the shape of CBT has become 'evidence-based'.

The field sites

The ethnography presented in this thesis consists, in a sense, of two ethnographies. The first is an ethnography of the professional world of psychological healthcare (primarily in the context of IAPT) which takes us from communities to conferences; the second ethnography is about the education and training of CBT therapists. These seemingly separate worlds form part of the same ethnographic reality of 'evidence-based psychological therapy'. CBT therapists graduate from IAPT-accredited university courses and psychological healthcare provided by the NHS consists primarily of different types of CBT provided by these therapists. 'Evidence-based psychological therapy' links university courses to psychological services and connects professional mental health conferences and policymaking with community centres and charities.

By pointing out the connections between my fieldwork locations (and indeed the coherence of the fieldwork itself), I do not mean to suggest a new ethnographic holism. Neither do I pretend to offer a panoramic ethnography of 'British mental healthcare' or even 'evidence-based psychological therapy'. My approach is more unassuming and suggests instead that connections between a range of field sites (and fieldwork experiences) 'do not add up to a whole but to a journey' (Candea 2010: 2). This ethnography is an account of such a journey traced, in which connections are necessarily always partial and locations arbitrary (Strathern 2004; Candea 2007).

This thesis then draws on fieldwork in and around more than one context in which evidence-based psychological therapy is sought. The following chapters set out these contexts in more detail. When I started fieldwork in the summer of 2016, I moved into a community centre where I volunteered as a coordinator of a 'wellbeing group'. The South London Community Centre[6] where I lived and worked for over a year was considered to be located in one of the poorer areas of London, a neighbour to the old Aylesbury Council Estate: this is a part of South London deemed notorious for its 'socio-economic' deprivation (see e.g. Exworthy et al. 2003). According to the NHS Foundation Trust of the region, it is also an area that has some of the highest rates of 'mental illness' and other health problems (NHS Digital 2018). When I moved into the Centre in August 2016, the administration had just received funding

[6] I refer to this community centre throughout the thesis by the pseudonym of the 'South London Community Centre' or simply 'the Centre'.

from the local NHS Trust to employ in-house psychotherapists to help increase access to the IAPT service.

In the meantime, I was also granted official permission to follow the training of mental health professionals at a postgraduate course in CBT. The director of the CBT course, a practising psychologist and lecturer, invited me to live with his family in the North of England where the University is based. I met the director, Philip, through a mutual friend in London as I was carrying out fieldwork on psychodynamic child therapy. When I later returned to Cambridge to begin my doctoral research, I was thoroughly intrigued by the idea of 'evidence-based' psychotherapy; CBT was everywhere evoked as a form of psychotherapy based on scientific evidence, supposedly unlike other kinds of psychotherapy. I eventually moved to live with Philip and his family in Cumbria, from where he also ran a private clinic as a CBT therapist. Having previously worked as a therapist in the IAPT service, Philip's main occupation was now as a university lecturer, teaching and supervising students in psychological therapies; he told me how he had trained 'hundreds of IAPT therapists over the past ten years' and many more CBT therapists over the past twenty years of teaching. I met his colleagues and students and I sat in on their classes, seminars, and clinical supervisions.

In between my commitments in South London and my training in the North of England, I attended conferences. Most of the conferences took place in big cities: London, Birmingham, and Manchester; others were held in Lancaster, Cambridge, and York. The conferences were diverse but related through common concerns with 'mental health' and 'evidence-based' practice. I attended professional conferences in clinical psychology, as well as several specialist conferences on the research, training, and clinical provision related to a range of evidence-based psychological therapies: most notably, Cognitive Behavioural Therapy, Behavioural Activation, Mindfulness-Based Cognitive Therapy, and digitalised CBT-based online courses ('computerised CBT' or 'cCBT'). There is also a growing market of 'public conferences' in the UK, many of which I attended. These were usually one-day NHS-related conferences promoting specific 'themes' such as the clinical application of research, new policies and their implementation, and strategies for outcome evaluation.

We might refer in institutional terms to these particular contexts of fieldwork – in which psychological therapies are sought and put to work – as a university, a charity, and a national healthcare service. 'The conference', as another aggregate of field sites, brought some of these contexts together, and the people and problems in them. Conferences, universities, charities,

and public services, including the governing and regulatory practices implicated in this complex of institutions, have all played their part in defining and shaping 'evidence-based psychological therapy'.

Categories in action

The terminology that features in this thesis requires some brief clarification. We will then be seeing certain terms or categories in action ethnographically – as part of people's own definitional realities (cf. Ardener 1982; Chapman 1978; McDonald 1989). For now, I touch here on three terminological points.

First, when dealing with 'evidence-based psychotherapy' as an ethnographic category, one immediate issue is that 'psychotherapy' in the singular can be misleading; much in the same way as we ('the anthropologists') might suggest that there is no one single practice or school of 'anthropology' (Candea 2018a).The singular 'it' is the result of reconciling multiplicity in spaces of coordination such as journals, courses, seminars, lecture rooms and conferences.

In British mental healthcare, a range of theories, techniques, and interventions that mental health professionals recognise as 'psychotherapeutic' or 'psychological' have generally been brought together under a single banner of 'psychotherapy'. Psychotherapy is often deployed in this way as an 'umbrella term' for multiple practices, subsuming them in a single classification.

'Psychotherapy' is often used to refer to both the practice of a specific intervention as well as the school of thought or theory that is seen to inform this intervention. 'Psychotherapy' is also a term used to refer to a set of distinct professional disciplines (Davies 2009) self-consciously differentiated from 'the discipline of psychology' (Bruun 2013). In turn, 'the discipline of psychology' comprises a range of disciplinary divisions such as 'forensic', 'health', 'occupational', 'clinical', and so on (including their many subdivisions).

The professional distinction between 'psychology' and 'psychotherapy' is now a common one in the UK, and I have seen it in action on several occasions. Clinical psychologists have often pointed out to me that they practise psychotherapy as part of their professional, clinical work, yet they are not psychotherapists in the disciplinary sense of the term. Distinctions are drawn up between psychotherapy as a profession (or a range of professions) versus a clinical practice (a type of treatment; e.g. 'psychotherapy' as opposed to 'medication'). Clinical psychologists have also in their own accounts of their discipline been eager to draw out a division of labour by which they occupy the top of an educational hierarchy, followed by

'psychotherapists' and then 'counsellors' (and, more recently, 'Psychological Wellbeing Practitioners') at the bottom – a hierarchy actively maintained in print and in person.[7] According to this professional hierarchy, psychotherapists usually cannot claim the title of 'psychologist'. (Although some psychotherapists are trained as psychologists too.)

The second terminological point I wish to make concerns schools of thought within psychotherapy. Histories of psychotherapy have typically distinguished between three main psychotherapeutic schools of thought; these are 1) psychoanalytic and psychodynamic; 2) humanistic, and 3) cognitive and behavioural (see e.g. Ehrenwald 1976; Rieber 1980). Each one of these schools consists of a range of approaches and theoretical orientations; for example, 'psychodynamic psychotherapy' refers to any psychoanalytic school seen to derive from Freud or any of the psychoanalytic schools after him (e.g. 'Jungian analytical psychology', 'Kleinian object relations therapy', 'Lacanian psychoanalysis'); the term might also refer to the 'expressive' or 'creative arts' psychotherapies (i.e., music therapy, movement therapy, psychodrama, art therapy, and play therapy). Likewise, the third school of thought referred to as 'cognitive and behavioural' itself covers a wide variety of therapeutic schools, derived in part from CBT, which include Mindfulness-Based Cognitive Therapy (MBCT), Compassion-Focused Therapy (CFT), Acceptance and Commitment Therapy (ACT), and many others (Dryden 2012).[8]

Both psychotherapists and psychologists could thus be described collectively as 'practitioners of psychotherapy' at the same time as we might recognise that 'psychotherapy' is a creature with myriad faces; as I have indicated, there are as many different schools and professions of psychotherapy as there are different 'subdisciplines' of psychology. (And, of course, not all psychologists practise psychotherapy.) It is perhaps because of this convoluted kinship network of 'disciplines', 'practices', 'professions', 'approaches' and 'schools' subsumed under the two broad categories of psychology and psychotherapy that a lot of confusion persists.

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[7] For recent historiographical examples, see the chapters written by clinical psychologists in Hall et al. (2015) – an edited volume that claims to offer 'the first history of British clinical psychology'.

[8] These latter subdisciplines are also known collectively as 'third-wave' therapies. The CBT literature distinguishes between three historical 'waves' of therapeutic orientations: the recent 'third' wave of cognitive and behavioural therapies is characterised by practices grounded in 'mindfulness', 'compassion' and 'metacognition'.

My third point concerns different terminological variants of evidence-based psychotherapy currently in circulation; the most common of these are 'evidence-based psychological therapy' (or 'therapies', in the plural) and 'evidence-based therapy' (also known as 'EBT'). These terms are used to distinguish 'evidence-based psychotherapy' from the broader movement of 'evidence-based medicine' (or 'EBM') from which it is said to derive (cf. Rowland & Goss 2000). In the following chapters, I use the terms 'evidence-based (psycho)therapy' and 'evidence-based psychological therapy' interchangeably, as do the practitioners and professionals I did my fieldwork with.

Whilst I think this brief clarification of terminology is necessary from the very outset – especially useful to readers who might well be unfamiliar with these common distinctions in British mental healthcare – this is a language of psychology which is of anthropological interest and it will receive further attention in the chapters that follow.

Anthropology and psychology

To many outsiders, the discipline of psychology is still intrinsically associated with the psychoanalytic movement. The latter is often said to have had its heyday in the first half of the twentieth century. Earlier histories of British psychology and psychoanalysis – often written by practitioners rather than historians – tended to emphasise an historical interchange between psychoanalysis and psychology, dominated at times by institutional competition and intellectual rivalry (e.g. Ehrenwald 1976). More recently, historians of psychology have pointed out the inadequacies of an historiographical delineation of 'psychology' as constituting a uniform discipline vis-à-vis psychoanalysis; indeed, other 'psy' disciplines and technologies have been constitutive of both and a history of psychology has proven to be rather more complicated (cf. Rieber 1980; Danziger 1997; Rose 1984; Marks 2017).

This historiography and the issues involved will not be repeated here. I have instead aimed to situate 'psychology' and 'psychotherapy' historically in Chapter 2 for the specific purposes of the thesis. Moreover, in situating this study in relation to relevant fields in anthropology (especially psychological anthropology, cognitive anthropology, and psychiatric anthropology), this thesis reflects on earlier anthropological studies whilst it seeks instead to contribute to a more rigorously ethnographic approach to, and understanding of, 'psychology' as it is lived and worked.

In the meantime, before discussing my approach in more detail, the following paragraphs offer some preliminary reflections on anthropology and psychology, including my own analytical language, after which we turn to the chapters of this thesis.

From psychoanalysis to cognitive science

Despite a great effort in the first half of the twentieth century by British psychologists to distance themselves from psychoanalysts,[9] anthropologists have tended to treat psychology and psychoanalysis somewhat synonymously. This treatment was perhaps due to the fact that both psychoanalysts and psychologists in the early twentieth century drew heavily on the ethnographic work of anthropologists in their own studies of 'human psychology' – and vice versa: anthropologists had long engaged with psychoanalytic theories in dealing with their ethnographic material despite their critiques of those same theories (see e.g. Malinowski 1927).[10]

In the aftermath of the Second World War, psychology acquired new importance and a professional standing in Britain (Derksen 2000; Jones 2004). It was also in the post-war decades that psychoanalytic thought made another appearance in British social anthropology but this time in the disguise of what became known as 'structuralism', which Claude Lévi-Strauss (1908–2009) had developed in France during the late 1940s and 50s (Lévi-Strauss 1963a).

It was only much later, with the establishment of 'cognitive science' – the so-called 'cognitive revolution' – from the 1970s onwards, and its influence on British social anthropology, that 'psychology' gradually came to occupy another conceptual space amongst anthropologists: it seemed as if anthropologists had moved from the mythic and symbolic universe of psychoanalysts (and Levi-Straussian structuralists) to the experimental laboratory of the cognitive scientists. In that move, some anthropologists began to challenge what to them appeared to be anthropology's ignorance of the discipline of psychology and the study of 'the

[9] Such efforts were primarily instigated by psychiatrists and later clinical psychologists based at the Maudsley Hospital and the Institute of Psychiatry in London before and after the Second World War, see Kohon (1986); Derksen (2000, 2001); Jones (2004); Marks (2015).

[10] Malinowski examined the Freudian Oedipus complex in the context of Trobriand kin relations and child development in his book *Sex and Repression in Savage Society* (1927), but famously dismissed any notion of Oedipal universality claimed by psychoanalysts of the day. Although Malinowski remained a critic of psychoanalysis and its 'exorbitant claims' throughout his career, he simultaneously acknowledged its contribution to important aspects of human psychology, especially its 'open treatment of sex' was in his opinion 'of the greatest value to science' (Malinowski 1927: vii–viii).

human mind' (Blount 2011). Cognitive science equipped anthropologists with an altogether different attention to 'the mind' from that which had been pursued by anthropologists inspired by Malinowski and Lévi-Strauss. Importantly, it included new evolutionary theories and experimental approaches to an anthropology of the human mind: 'cognitive anthropology' was born (Irvine 2018). Cognitive anthropology also sought to put an end to the Durkheimian separation of 'the social' from the 'psychological' and 'biological' that had informed so much of anthropology.[11]

It was also around this time that academic textbooks on psychology started to define psychology as 'the science of mind and behaviour' (e.g. Gross 2012 [1987]). This particular self-definition was partly pursued in opposition to former psychoanalytic and psychotherapeutic schools considered now 'pseudo-scientific'.[12] Sigmund Freud (1856–1939) and many of the prominent psychoanalysts who came after him (such as Carl Gustav Jung, Melanie Klein, Alfred Adler, Jacques Lacan, and Wilhelm Reich – to name just a few) were confined to the footnotes of these textbooks and mostly discredited. Key psychoanalytic ideas were now increasingly seen to threaten a self-consciously 'scientific' psychology that sought company with medical science and psychiatry rather than with psychoanalytic psychotherapy.

One striking consequence of this reputed 'new science' of psychology was that psychoanalysis was accused of having inflicted, for decades, parental blame and personal guilt in the therapeutic world; not only was psychoanalysis deemed profoundly unscientific by methodological standards, it was also rejected as morally dubious for holding patients (or their parents or relationships) responsible for their experience of psychological distress. An assertively *biological* psychiatry arose in its place, especially in the US (Luhrmann 2000), but also in the UK where a 'neuro'-science came to the rescue.[13] Contrary to psychoanalytic psychotherapy, a biomedically-orientated psychiatry asserted that the disturbed or distressed

[11] Maurice Bloch (2012) has more recently proposed a reinvigoration of a cognitive anthropology, although many of his sentiments (such as his suggestions of incorporating and accounting for 'psychology' in anthropology) are not particularly new (see e.g. chapters by Boyer and Sperber in Whitehouse 2001).

[12] This is a point we return to ethnographically in Chapter 5.

[13] The constellation of psychoanalysis, on the one hand, and psychiatry and clinical psychology, on the other, differed significantly between the US and the UK; psychoanalytic training and practice had been central to American psychiatry and clinical psychology (as opposed to their British equivalents) up until the 1980s and it was against this institutional status of psychoanalysis that a self-consciously 'biological' psychiatric science took shape (Luhrmann 2000). In the UK, psychoanalysis never gained such institutional prominence in psychiatry and clinical psychology (even if it remained popular amongst well-educated people) where behavioural psychotherapeutics had taken the lead since the Second World War, pioneered by psychological research at the Maudsley Hospital in London (Marks 2015).

mind was a result of a biologically dysfunctional brain; it thus appeared to locate responsibility elsewhere, namely in the genetic make-up and biochemical mechanisms of 'the brain'.[14] 'Mental illnesses' were no longer anyone's fault: they were instead discrete 'disorders' that could be detected in 'the brain' of afflicted patients. Moral responsibility seemed to have been dispensed with; psychiatric diagnosis and intervention are necessarily 'objective' affairs. The fact that psychiatry sought to redefine itself as a discipline based firmly on scientific medicine means that many practitioners still feel that they are dealing with clinical matters beyond 'moral definition' (McDonald 2011). British psychology followed, for the most part, in the scientific footsteps of psychiatry.

However, despite the general rejection of psychoanalysis within British psychology, it had nevertheless offered an important language against which psychology built its psychological laboratories in the UK. Psychoanalysis seemed to have come and gone but it had left behind a language of 'human psychology' that remained pervasive in British society as well as in clinical psychology (Danziger 1997; Rose 1989, 1996). Owed to psychoanalysis were now common concepts with which to talk about a perceived internal selfhood: 'the psyche', 'ego', 'personality', 'fantasy', 'unconscious', 'dissociation', 'motivation', 'repression', 'trauma', and so forth.

In the meantime, earlier generations of social anthropologists have generally tended to dismiss or ignore the discipline of psychology, often portraying it as an embarrassing descendant of Freudian psychoanalysis or the discipline of an equally problematic evolutionism and reductionism, as in the case of evolutionary psychology (see e.g. debates in Whitehouse 2001; see also Bloch 2012; Irvine 2018; Introduction in Navaro-Yashin 2012). However, most present-day clinical psychologists feel that they have long ago moved beyond Freudian psychoanalysis (Bruun 2013, 2014), and many also take issue with the crude evolutionism and reductionism of the kind that anthropologists have often alluded to in discussions of psychology as a discipline.

This critical tendency amongst anthropologists can in part be traced back to the early anthropological critics of psychology and psychoanalysis, in particular Edmund Leach and later

[14] Littlewood (2002) describes these epistemological models of mental illness as 'personalistic' versus 'naturalistic' explanations pertaining respectively to a psychotherapeutic versus a biological psychiatry. 'Personalistic' because the 'illness' is perceived to be intrinsically implicated in the constitution of 'the person' contra 'naturalistic' aetiologies in medical pathology.

Ernest Gellner, two formerly prominent figures in British social anthropology, both of whom were based at Cambridge University.

In Leach's well-known article 'Magical Hair' published in 1958, psychologists and psychoanalysts are conjointly treated as practitioners of a discipline against which are ranged anthropologists and sociologists (Leach 1958). In his article, Leach challenges the psychologist 'Dr Berg' who, he claims, uses ethnographic accounts – in the style of Freud – to act as empirical evidence for the universality of psychoanalytic theories such as the symbolic acts of 'castration' in ritual or the unconscious link between hair and sexuality ('phallic symbolism') in different cultures. Leach critiques the symbolic interpretations that psychoanalysts attend to in their analyses of 'the inner psychic states of the individual'. He argues that psychological analysis and anthropological analysis are intrinsically unalike. According to Leach, they are even 'irrelevant' to each other: the psychoanalyst is 'concerned with the inner feelings of the individual' as opposed to the anthropologist, who studies 'symbolism as expressing states of the social system rather than the states of the individual psyche' (Leach 1958: 168). Leach proposes a division of 'public' and 'private' symbols, the 'collective' and 'individual', 'external' and 'internal' (evoking again familiar distinctions associated with Durkheim and others):

> This distinction between public and private, social and individual, is one which constantly concerns the social anthropologist. In most situations he will be well advised to leave psychological matters to psychologists and stick firmly to the public sociological facets of the case. (Leach 1958: 148)

We could summarise Leach's argument as suggesting that psychology and anthropology constitute two different practices of knowledge production, two distinct epistemologies. Nonetheless, Leach's engagements with structuralism and the work of Lévi-Strauss (see Hugh-Jones & Laidlaw 2000), and the introduction of both into British anthropology, speak of his longstanding interest in aspects of psychoanalytic thinking. It is clear from Levi-Strauss' own ethnographic work that 'structural anthropology' owed a great deal to psychoanalytic theories (e.g. Lévi-Strauss 1963; see also Ingham 1996; Moore 2007).

One of the first documented attempts to study a 'psy' discipline ethnographically was made by Ernest Gellner, who had approached the British Psychoanalytic Society in order to undertake fieldwork on psychoanalysis. As noted earlier however, Gellner was never granted access by the Society who had repeatedly turned down researchers. Lacking proper fieldwork research, Gellner nevertheless produced a book (1985) on psychoanalysis – drawing very much

on his former training in analytical philosophy – in which he examined psychoanalytic theories as a 'self-protected system of belief', and the prevalent influence of psychoanalysis on the understanding of 'emotion' in the British middle-classes. Gellner's work offered a stark critique of psychoanalysis.

Taken together, Leach and Gellner's work implied that anthropologists cannot, and should not attempt to, get into people's heads as it were (anthropological knowledge was instead to be based on observations of 'social' or 'external' representations such as behaviours and symbols). Such convictions in British social anthropology were rather conventional at that time, and they were also in keeping with Malinowski's empiricist sentiments, some of which still tend to hold epistemological reference in social anthropology today.

This kind of (functionalist and structuralist) empiricism has since been called into question (Ardener 1971; Candea 2018b), as has the aforementioned dichotomies. (Although various versions of these dichotomies – internal/external, cognitive/cultural, individual/social, private/public, and so on – still feature in much contemporary anthropology.) This thesis follows on from an anthropology (see Cohn & Lynch 2017; Latour 2004a; McDonald 2012a; Toren 2012a) that has decisively moved beyond these problematic bifurcations associated with an older social science. In other words, this study presupposes no analytical 'division of our universe' (Candea 2011) into 'outer' and 'inner' worlds, and it grants no a priori status to psychology and anthropology as having a privileged or intrinsic access to either world. Such notions are not to be taken for granted in the following pages; they are instead very much a part of the ethnographic subject-matter under study – as part of the assumptions and theories that the people studied might have of themselves and others and the world in which they live.

Foucault and the study of 'psy'

Michel Foucault (1926–1984) has arguably been one of the most influential theoretical pioneers in the study of psychoanalysis, psychology and psychiatry in the humanities and social sciences. Anthropologists' engagement or disengagement with Foucauldian frameworks has been analytically formative in the study of the psy disciplines.

At one end of the spectrum of this literature, we find social scientists dedicated to a critical scrutiny of everything 'psy', building on Foucault's work on the emergence of psychopathology and its institutions, as well as his work on 'governmentality' (Foucault 1973, 1988a, 1991). This

body of Foucault's work[15] was taken up and analytically elaborated in a series of critical histories of the psy disciplines by Nikolas Rose in the 1980s and 90s (Rose 1984, 1989, 1996). Rose and others have demonstrated how psychotherapeutic and psychopharmacological institutions and practices have constituted new forms of political subjection and self-governance, new configurations in 'governmentality' and 'biopolitics' (see e.g. Rose 2006; Burchell et al. 1991; Rose & Abi-Rached 2013; Jenkins 2010). The crux of the arguments that run through much of this literature is the contention that, in the name of expertise and care, psychiatry and psychology conceal and work through specific moral and political ideologies that shape the ways we come to know, relate to, and act upon ourselves and others.

Some anthropologists have gone further. Deploying a similar Foucauldian critique, they have argued that as psychiatry has become installed as the authority concerning what it means to be 'normal' or 'mentally ill', partly through the making and remaking of the international classifications of the DSM (*Diagnostic and Statistical Manual of Mental Disorders*), it has succeeded in establishing itself as the paramount authority on the provision of therapeutic treatment for these classified disorders, generating a profit-making market of psycho-pharmaceuticals – drugs that have, it is argued, 'done more harm than good' (Davies 2013). This literature targets modern psychiatry and the pharmaceutical industries in particular (e.g. Borch-Jacobsen 2012; Kirk 1999) and it has echoes of earlier critiques that came out of the anti-psychiatry movement of the 1960s and 70s (Szasz 1974). This was a movement influenced by Foucault's early suspicion of everything 'psy' and his history of the invention of madness which appeared to expose psychiatry in many ways as a structural oppressor (Foucault 1988b [1961], 1988a [1962]). Foucault's scholarship thus had a significant impact on intellectual anti-psychiatry critics (many of whom held academic positions in psychiatry, see e.g. Szasz 1974), although he often distanced himself from the direction in which they took his work.

The ethnographic work of Tanya Luhrmann (2000) can be read as an objection to the kind of critical studies of the psy disciplines I have just mentioned. Luhrmann refrains from situating her study of American psychiatry in terms of Foucauldian governmentality, deeming such social science perspectives a naive romanticism that does little justice to the suffering subjects:

[15] It should be noted that Foucault's history of 'the medical gaze' and 'the clinic', as well as his general critique of psychiatry, form part of his earlier work; his much later work on ethics, truth and freedom (e.g. Foucault 1990, 1997) can be read as a significant rethinking of his earlier theories of power and subjectification (Laidlaw 2014, 2018).

'Foucault did presume that madness had always existed, but he romanticised it in a way that, despite all his insights, did a terrible disservice to its pain. […] Madness is real, and it is an act of moral cowardice to treat is as a romantic freedom.' (Luhrmann 2000: 10-12). Instead, Luhrmann identified two competing paradigms in psychiatry: the psychotherapeutic model (informed by psychoanalysis and psychotherapy) and the biomedical model (informed by molecular biology, psychopharmacology and neuroscience) and provided an ethnographic account of the epistemological and empirical conflicts between talk therapy and drug therapy, and the medico-moral consequences of losing the former to the latter.

James Davies' (2009) work on the training of psychoanalytic psychotherapists in England seeks to build on Luhrmann's study of psychoanalysis. Davies also seems echo Luhrmann's general dismissal of Foucault's genealogies of the psy disciplines. Instead, Davies sets out to explore how 'individual subjectivity' is shaped by 'institutional mechanisms of socialisation' by studying people within their educational and professional environments – that is, the psychoanalytic institutes and training centres. Drawing on Durkheim and Bourdieu, Davies makes the case that psychoanalytic trainees engage in a formative process of 'professional socialisation' within a 'moral and cultural community'. He argues that, by means of 'hidden institutional devices', the process of socialisation transforms trainees (who typically start out as patients) into loyal practitioners who come to sustain and reproduce the values and practices of the psychoanalytic tradition (Davies 2009: 2-3). My research thus also seeks to follow up on both the work of Luhrmann and Davies with an anthropological study of CBT therapists.

In summary, the Foucauldian literature discussed above could be read now as an important intervention in the historiography of the psy disciplines, as seeking to destabilise the discursive power of their institutions, pathologies and therapeutics. However, Foucault's work concerned with mental illness can also be seen to reflect his own vehement criticism of the status and attraction of psychoanalytic theory more generally amongst French intellectuals. In British social anthropology, a profound disquiet with the psy disciplines was partly encouraged and shaped by this particular body of Foucault's work. Before him, figures such as Durkheim (2008 [1912]) and Malinowski (1927) had long moved the 'social' away from the 'psy', albeit for different reasons. Some anthropologists, self-consciously practising a *social* science, strived hard to distance themselves from the work of psychoanalysts and psychologists as part of a division of labour, as exemplified by Leach's account above (1958). Others quite simply rejected psychoanalytic ideas that had gained traction in the 'culture and personality' school that arose

in the US during the 1930s, and which is considered to be the forerunner of the American subdiscipline of psychological anthropology that took shape in the 1970s and 80s (cf. LeVine 2010; Schwartz et al. 1992). An unease with psychoanalytic theories can be seen to extend through British social anthropology quite broadly now, although some anthropologists have called for serious re-engagement or collaboration with psy disciplines and related fields, from psychoanalysis (e.g. Moore 2007) and psychiatry (e.g. Luhrmann & Marrow 2016) to neuroscience (e.g. Northoff 2010) and cognitive science (e.g. Bloch 2012).

Whilst ethnographic examinations of Euro-American renditions of the individual, autonomous 'self' remain relevant (see e.g. Battaglia 1995; Macfarlane 1994; Morris 1994), and Foucauldian critiques of the 'psy'- and 'neuro'-sciences of the kind mentioned above still have a stronghold in anthropology, it is Foucault's later work on ethics, subjectivity and truth (e.g. Foucault 1997) and his volumes on the history of sexuality (Foucault 1988c, 1990, 1992) which have inspired anthropological work more recently. This body of work has injected analyses with new enthusiasm, leaving some of the 'darker' conclusions of Foucault's earlier work behind (cf. Ortner 2016; Laidlaw 2016, see also 2018).

It is also Foucault's work on 'ethical self-formation' which has been particularly instructive over the past twenty years in shaping a range of anthropologies of ethics, morality and subjectivity (see e.g. Faubion 2001, 2011; Boellstorff 2005; Laidlaw 2002, 2014; Moore 2011; Robbins 2013; Brodwin 2013; Mattingly & Throop 2018). Recent anthropological studies of psychological therapies have followed this sweeping current: Joanna Cook (2015) and Else Vogel (2017) have both explored mindfulness-based therapies as practices of self-care with reference to Foucault's theory of 'reflective thought' and 'self-cultivation'.

What kind of ethnography is this?

Ethnographic writing can sometimes imply a certain taken-for-granted distinction between an academic world and an ethnographic one. Such a conceptual division is not always readily maintained in this thesis. Rather, the contexts and people under study in this thesis often shift between and traverse common boundaries: occasionally, aspects of my own academic world became ethnographically interesting as some of the people I studied (i.e., mental health professionals) were themselves occupying an academic context much like my own – many collect data, investigate, analyse, comment, and critique; they attend academic seminars, workshops and conferences. In other words, the people I studied were fully capable and willing

to 'talk back' (Brettell 1993), as they often did during my fieldwork.[16] Ethnographic distance is therefore not always given beforehand.[17]

Anthropologists have long been aware of, and have had to deal with, ethnographic realities within which their own analyses risked being eaten alive, as Edwin Ardener was keen to point out (Ardener 1971; see also McDonald 2007 [1989]). The people or realities we set out to study might not always be unlike ourselves or our academic homeland. These circumstances necessarily challenge any *a priori* distinctions we might have tacitly drawn up for ourselves between the anthropologist and those under study. It is also a point of methodological reflexivity concerning anthropology's own epistemological assumptions, such as the differentiation between theory and ethnography or data. Although this is far from a new concern in anthropology, some recent 'turns' to ontology – the most vocal of which have been brought together and recognised under the single banner of 'the ontological turn' (Holbraad & Pedersen 2017) – have complicated that cherished distinction further, but in a way that is in itself inherently 'theoretical', as Paolo Heywood (2018) astutely demonstrates. The ways in which we thus draw up, and draw on, ethnographic 'framings', as Matei Candea (2005) has put it, have significant implications for how we proceed with an anthropology seemingly 'at home'. Bringing anthropology closer to 'home' – closer to the contexts in which anthropology itself emerges, lives and thrives – has its merits as well as its limits (Strathern 1987). It is not always an easy homecoming.[18]

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[16] This is not, of course, a novel condition by any means. As Americo Paredes noted in the 1970s: 'It was one thing to publish ethnographies about the Trobrianders or Kwakiutls half a century ago; it is another to study people who read what you write and are more than willing to talk back' (1978: 2). More than a decade later, Renato Rosaldo amongst others reflected that 'social analysis must now grapple with the realization that its objects of analysis are also analyzing subjects who critically interrogate ethnographers' (1989: 21).

[17] For example, practitioners of evidence-based healthcare frequently read and comment on social science studies of their professional practices, programmes, services and so on. It would be a misleading account of evidence-based psychological therapy if I simply proceeded by keeping to a ready-made and unambiguous distinction between a world of ethnographic subjects (mental health professionals) contra a world of academic commentators (anthropologists and other social scientists).

[18] Whilst the debates about anthropology's homecoming are not new (see e.g. Jackson 1987), many of the issues discussed four decades ago still seem embarrassingly relevant today. For example, in a *Current Anthropology* article from 1986 on the study of minority language enthusiasts in France – many of whom were themselves social scientists – Maryon McDonald aptly observed, in reply to some condemning comments from anthropological colleagues, that: 'some of the commentators' responses themselves illustrate how very difficult it is to hold our own ways of thinking up for inspection, to allow that some of our most cherished ideas and assumptions might be not unproblematic handles on history and anchors on reality, but as fit a subject matter for ethnography as any of the other worlds, socially and geographically more distant, that we have more comfortably subjected to our anthropological gaze' (1986: 344).

Pointing out these concerns here, hopefully goes some way to direct the reader through the intersection of those people directly involved professionally in evidence-based therapy and those professionals who comment on evidence-based practice (i.e., historians, philosophers, public health scholars, and other social scientists). Indeed, many mental health professionals themselves are critical commentators on the problems and limitations pertaining to their own 'evidence-based' practice, as we will see throughout the thesis. I hope the following chapters go some way to pay heed to the critical multiplicity found within the same professional spaces that I have tried to do an ethnographic account of.

Similarly, it became clear to me during my fieldwork that there was no privileged position from which I could comment, as an anthropologist, on the issues I encountered in psychological healthcare without being cast as just another commentator – another voice amongst many others. My account then (and any of its descriptions, insights, critiques) can undoubtedly expect to be absorbed into the same ethnographic reality that it portrays as yet another 'perspective' on issues that have, for some time now, attracted considerable debate in the UK. Within such a context (and contestation) of perspectives, this thesis might likewise expect to be subsumed under either one of two broad categorisations that have taken hold of these debates about psychological therapy: 1) those who seek to promote, or are otherwise supportive of, evidence-based psychological therapy and 2) those who are opposed to its convention, claims, and institutionalisation.

This point has been exemplified to me not only during fieldwork but also in the presentation of aspects of this research amongst peers and other social scientists. Over the past years, I have been asked to respond to questions along the lines of whether the IAPT service deserves support or not; 'are you for or against CBT?', 'what is the solution?', and so on, were common responses to my research topic. However, the aim of this research is not to arrive at a set of 'solutions' (this has also become increasingly expected of doctoral research in the social sciences). Nor do I consider it the job of the anthropologist to arrive necessarily at such conclusions. In saying this, I do not mean to suggest that we – the ethnographers, the analysts – are somehow free of normative assertions. But normativity might not always be what the anthropologist wants to add to the conversation. Although this research does not seek definite answers to these questions ('is the IAPT service good or bad?', 'should we invest in CBT or not?', etc.) – answers which involve, I think, a more complicated grasp and interrogation of both 'for' and 'against',

'yes' and 'no', and for whom or what exactly something is 'good' and 'works' – I feel that some answers are nevertheless contained in the ethnography itself.

These issues have required some rethinking of my own analytical language and framing. One immediate issue has to do with anthropological theorising and conceptualisation familiar to psychology. As I have indicated above, few anthropologists could be said to have taken psychology and cognitive science securely out of their conceptual toolkits to find it deserving of ethnographic scrutiny. Anthropology and the psy disciplines have long tended to come together in intellectual engagement (for a critical summary, see Toren 2012a; Hickman 2010)[19] – producing, for instance, 'cross-cultural' studies of mental health issues such as schizophrenia (for a recent example, see Luhrmann & Marrow 2016). Such collaboration or interdisciplinarity has been, and remains, the intellectual backbone of some work done in anthropology, especially in those subdisciplines known as cognitive anthropology and psychological anthropology, and including some strands of medical anthropology, too (see e.g. Kleinman 1988; Frake & Tyler 1987; Ingham 1996; Littlewood 2002; Whitehouse 2001; Luhrmann 2006; Quinn 2006; Bloch 2012; Mair 2018). This kind of anthropological work has its own merits, but it is the empirical problems and limitations of such work that are of interest here.

One such limitation is this: when anthropologists assume or uncritically reproduce in their own work the same definitional realities that are shaping, and have been shaped by, psychology – be it even general concepts such as 'cognition' or 'introspection', for example, or any of their other ontological and epistemological presuppositions – they are inevitably engaging in precisely the same processes that I want to hold up for inspection in my ethnography.[20] So although we might be tempted, in the following chapters, to talk about people and care practices in terms of 'subjectivity', 'cognition', 'reflective thought' and cognate terms – or even take on board notional distinctions such as 'physical health' versus 'mental health' or any other mind/body dualism – this thesis encourages a shift in which such notions are dispensed with analytically. In the meantime, there have been several attempts to stabilise these concepts as theoretical and analytical constructs for better or worse in anthropologies of religion, ethics

[19] In British social anthropology, an intellectual alliance between anthropology and psychology might be traced back to the fabled Cambridge Torres Straits Expedition in 1898 (Haddon 1901), especially the work of the experimental psychologist-cum-anthropologist W.H.S. Rivers (see e.g. Rouse 1999; Pickles 2009), who is also credited for having established psychological laboratories at the University of Cambridge and University College London (Sullivan 2012).

[20] 'Holding up for inspection' is owed to McDonald (1986).

and morality, including cognitive, psychological and medical anthropologies.[21] It is, however, the capacity of these ideas to persuade and the realities they inform which are of interest to this thesis.

There are many such notions then which, for an anthropologist working in the world of the psy-disciplines and their practices, have ethnographic interest rather than becoming part of the anthropologist's own analytical language. Treating this world 'ethnographically' is meant here in the basic but nonetheless important sense of 'rendering strange' a set of assumptions or entities – including those that may be presupposed by the theories and categories that anthropologists often use and share with psychologists. Rendering strange however should not be taken as an exercise in exoticism as other anthropologists have pointed out (see e.g. Hastrup 1995); rather, my point is equally about rendering more familiar the familiar in anthropology. Indeed, this thesis could be read as an exercise in improving a more general awareness in anthropology of how our own ways of theorising and categorising have much more in common with the conceptual world of psychologists than anthropologists have cared to acknowledge and investigate.[22] This sharing of pre-theoretical commitments, we might say (Moore 2004), is not always of concern to anthropologists for various reasons, but this thesis attempts to encourage us to make a constructive necessity out of examining those knowledge practices closest to us, and which may at times include our own. To put this point in a different way, this study investigates how certain assumptions about care and selfhood ('mental health') have become widespread and culturally meaningful in the UK; that is, how people understand themselves and others through the psychological realities of CBT and IAPT; how people might

[21] The concepts of 'mind', 'self', 'cognition', 'psyche', 'subjectivity', etc., have been variously deployed in these fields and the literatures are extensive; recent examples, which have been particularly influential, include amongst others: Biehl et al. (2007); Bloch (2012); Laidlaw (2002); Luhrmann (2006); Mageo (2002); Moore (2007); Quinn (2006). For critical commentary on some of these concepts in anthropology, see e.g. Battaglia (Battaglia 1995); Navaro-Yashin (2012); Strathern (1995); Toren (2012). For critical histories, see e.g. Danziger (1997, 2008) and Rose (1984, 1989, 1996).

[22] Toren & Piña-Cabral (2011) have expounded in more general terms on a similar sentiment in their discussion of epistemology in anthropology. I fully agree with them when they say: 'We want to see a more general awareness that analyzing ethnographically the lived world of those closest to us (including ourselves) is just as tall (but no taller) an order as analyzing and understanding those distant others who seem most exotic to us. […] In no case is the relationship between researcher and researched to be taken for granted […] because what is at stake here is the very possibility (or not) for an engagement with other human beings, whoever they may be […] This taken for granted has everything to do with the fact that, apart from studies of scientific practice, there is little ethnography concerning our own processes of knowing (often held to be the province of psychology) … and too rarely do anthropologists question the set of entities presupposed by the theories they use' (2011: 2).

live, use, confirm, resist or reinvent such ideas about mental health, and some of the consequences, as psychological therapies continue to proliferate and persuade.

Outline of Chapters

The thesis consists of six chapters plus a conclusion. Chapter 1 introduces a community centre in South London with particular reference to its 'wellbeing programme'. This chapter explores how psychological healthcare has been envisaged by the IAPT service and how 'access' to such care has been problematised. I argue that the inventors of IAPT have framed a reported crisis of mental health and wellbeing in the UK as a question of 'improving access'; meanwhile, access has been further problematised by IAPT therapists themselves working in communities where such 'access' to psychological therapies has been deemed lacking. We will see some of the caring capacities of the work of IAPT therapists beyond IAPT's own clinical context and a perceived 'medical model'. I suggest that the effects of their efforts to improve access to psychological healthcare are not reducible to, nor necessarily always in the service of, IAPT or 'evidence-based' therapy. The central ambition of improving access to psychological therapy has proven rather more complicated and inventive: IAPT therapists could be said in practice to have enlarged and consolidated the 'psychotherapeutic' to include other modes of care. I suggest that the ethnographic material in this chapter points to the limitations of theories of (bio)medicalisation/de-medicalisation.

In Chapter 2, we pause for a moment to consider some of the historical trajectories that have shaped what we might recognise today as 'mental healthcare' in Britain. The chapter follows the significance of psychotherapeutics through a brief history of institutional formations from the asylum and mental hospital, through to the Tavistock Clinic and Maudsley Hospital, to the invention of 'evidence-based psychological therapy', with CBT at its core. The chapter thus offers a brief but important excursion into historiography and a more recent history of IAPT's invention as the product of clinical psychology and 'happiness' economics.

Chapter 3 examines in more detail the structure of the IAPT service and the problems therapists experience as they are called upon to 'monitor' psychotherapy. We will see why some people regard IAPT's model of public psychological healthcare as worrisome, whilst others endorse the avowed effectiveness and need of such a model. All of this takes shape around some common critiques of the service in particular, and the role and significance of psychological therapy more broadly. This chapter points to some tensions in the ways in which social

scientists have tended to situate and theorise psychological worlds and how practitioners in such worlds have done their own situating and self-commentary. We will see that an anthropological analysis may not always differ significantly from what is already contained ethnographically in the critical discourses mobilised here by the mental health professionals themselves.

In Chapter 4, we follow the training of therapists in evidence-based psychological therapy through an IAPT-accredited university course in Cognitive Behavioural Therapy. I argue that CBT is constituted through, relies on, and instils a particular diagrammatic vision of 'human psychology'. We will see that learning to work therapeutically involves an affective engagement on the part of the student through articulations with working objects and all the circumstances of the therapeutic learning environment. The students acquire therapeutic skills by becoming more sensitive to ever keener distinctions. In the practice of psychotherapy, these distinctions are thereby themselves rendered articulate in the theories, models, consultations, records, patients, clinical guidelines, and everything else that make up 'CBT'.

Chapter 5 explores professional conferences as important occasions in which the self-definition of evidence-based psychological therapy is sought. By engaging some historical specificities on the question of 'objectivity', and by relating these to the discipline of psychology, this chapter attempts to describe how IAPT professionals understand 'evidence' and, in turn, how psychological therapy construed as an object of scientific observation has been pursued. Psychological therapy, I suggest, has longed strived to be recognised as the product of science, but with 'subjectivity' as its scientific object. It could be said to have finally achieved such recognition, at least in the UK, but it is also because of this achievement that empirical problems have continued to loom large.

In Chapter 6, we end with the therapeutic practice of CBT itself and with another prominent 'evidence-based' therapy introduced into the IAPT service: Mindfulness-Based Cognitive Therapy (MBCT) or 'mindfulness'. This chapter examines some therapeutic specificities of psychological therapy as we move from CBT to mindfulness. Whilst mindfulness therapy is said to have been derived in part from CBT, it is in the juxtaposition of these two therapeutic models that serious tensions are experientially confirmed. I argue that whilst CBT and mindfulness have both been recognised as effective interventions for a range of mental health problems, they have also generated their own therapeutic uncertainties. Psychological therapies

have come to shape conflicting models of 'the mind', with different notions of selfhood effected through these practices.

Contribution and Argument

The thesis contributes to anthropological studies of mental healthcare through presenting new empirical material on psychological therapy through ethnographic reflections on a group of mental health professionals who tend to be absent from such studies: clinical psychologists and psychotherapists. More particularly, the thesis presents the first anthropological study of CBT and the IAPT service (as far as I am aware at the time of writing). As I have indicated, only a few anthropologists have carried out fieldwork on the topic of psychotherapeutics – and these studies have focussed on psychoanalysis or psychopharmacology (Luhrmann 2000; Davies 2009; Jenkins 2010). Others have addressed the profession of clinical psychology in their work but this has often been in passing rather than as a main ethnographic focus (see e.g. Calabrese 2008; Meyers 2013; Young 1997). Clinical psychology and psychological therapies, therefore, have remained surprisingly peripheral in anthropologies of mental health, which have historically been occupied with psychiatry rather than psychology (see e.g. Kleinman 1980; Littlewood 2002; Brodwin 2013). Recent attention to mindfulness-based therapies in the UK (see e.g. Cook 2015, Drage 2018, Wheater 2017) seems to move us closer to approaching psychology and psychologists as objects of enquiry. However, many ethnographers remain committed to some strand of psychological anthropology or 'cross-cultural' research (see e.g. Long 2018; Luhrmann & Marrow 2016; Mair & Cook 2018; Martin 2019) rather than conducting an anthropology *of* psychology as this thesis encourages.

The overall focus of this thesis lies in the intersection of three topics that I would summarise as professional training and practice, accountability and scientificity, and models of care and selfhood. It is through these intersecting concerns, and through a diverse set of contexts in which evidence-based psychological therapy is sought, that the thesis contributes with anthropological material to an emerging debate on IAPT just as it is becoming a key component of contemporary mental healthcare in the UK (Pickersgill 2019a, 2019b; Marks 2018a).[23]

[23] This debate has so far been characterised by scholars within the history of science (Sarah Marks) and within sociology and STS (Martyn Pickersgill) whose studies are based on interviews and archival/textual research.

Rather than focusing primarily on clinical encounters or the 'patient experience', this thesis investigates the principles underlying psychological therapy, how they are conveyed through training and conferences, and how practitioners make sense of them in their everyday work. It examines some of the histories and logics that underscore the invention of a national psychological healthcare service, how psychological therapies align with dominant discourses in biomedicine concerning treatment and evidence, and more fundamentally, some of the assumptions concerning ideas of selfhood that are implicit in them. We will see how professionals acquire particular skills and sensitivities in order to be practitioners, how within specific professional contexts they debate and disagree with each other, yet also how they try to resist certain hegemonic values and expectations externally, beyond such contexts.

The thesis interrogates a set of common bifurcations and framings in the anthropological literature that are often mobilised to critique, contextualise or represent various aspects of mental healthcare. I argue that the salience of the IAPT service and the tensions and debates it has generated reside in its advocates' efforts to redefine putatively political, social and economic issues as matters of psychological concern and competence through the notion of national mental health or wellbeing, with a problematisation of access and of mental ill-health (especially the category of 'depression') and a consequent call for psychological intervention in the form of CBT. It is these recent changes in the rationale behind, and in the delivery of, a public psychological health service that have, in turn, been cast by many critics and mental health professionals alike as inherently 'political' and 'economic' moves, but moves that have nonetheless been hailed as necessary in solving a reported national mental health crisis. It is, however, the general deflection of critique by the founders of IAPT that has served to both obscure and prevent certain forms of critical scrutiny through which other models or approaches to psychological healthcare could be appropriately envisaged and enacted.

The thesis suggests that the epistemic success of CBT as the benchmark model of psychological healthcare in the UK rests on a persuasive, recursive constitution of psychological therapy: CBT introduces accountability and measurement at the heart of its proposed vision of mental health – enacted through particular therapeutic practices of self-reporting and self-inspection – and this in turn enables it to demonstrate its value and validity in the terms set by the conventions of 'evidence-based' practice.[24] This thesis will suggest that

[24] I am grateful to Matei Candea for encouraging me to state this argument explicitly here.

the institutionalisation and widespread acclaim of the IAPT initiative, as well as the daily problems and concerns that practitioners now experience, are grounded in the persuasions of a self-consciously 'scientific' model of psychological therapy that has to reflect a commitment to evidence-based medicine.

As a result, psychotherapeutic care has been reconstituted as a highly manualised, standardised and quantifiable intervention. It is the quest for scientific validation that requires psychological therapy to be enacted as an object of scientific testing through clinical trials by way of rendering the human subjecthood at the core of its practice amenable to measurement and diagnostic classification. This pursuit of objectivity hinges on the transformation of its antithesis, 'subjectivity' – the foundational object of psychotherapeutic practice – into a particular epistemic object that can be scientifically tested and intervened upon. Such an ambition is not new in psychology, as we shall see, but it has been revivified in new and interesting ways through the promises and ideals of evidence-based psychological therapy.

I refer to these central points of the thesis as the *scientific persuasions* of psychology.

chapter one

A community of care

A caring reality

'There is no doubt that CBT works. It really works. But it doesn't leave a lot of space for people to be human: to be contradictory and complex beings', Paola tells me as we sit down in her office to discuss her work as a psychotherapist in the 'Improving Access to Psychological Therapies' (IAPT) service. 'However,' she continues, 'evidence-based psychotherapy is the only way to run an NHS service like IAPT. The medical model is the only way to do it.'

According to Paola, and other mental health professionals like her, psychotherapy has become conceivable and workable within a 'medical model' of public healthcare.[25] The launch of the IAPT service in 2008 as part of NHS England was widely promoted by its founders – the economist Richard Layard and the clinical psychologist David Clark – as an initiative to improve access to evidence-based psychological therapy. A majority of mental health professionals appear to have been supportive of the initiative at the time; the launch of IAPT was felt not only to be an official recognition of the scientific validity of clinical psychology (and related professions) but also a necessary improvement of public mental health services (see Pickersgill 2019a, 2019b; Marks 2018a). When I began my fieldwork, I met many mental health professionals like Paola who felt that this improvement had been achieved within a medical model of care, and it was deemed 'the only way' to run a public psychological health service.

This chapter opens up one of the guiding questions of this thesis: how has evidence-based psychological therapy become conceivable and workable? And with what effects? We will see in more detail some of these empirical effects in later chapters. In the following, I explore this question in relation to an ethnographic concern with 'care'. This chapter puts forward a number of interlinked observations that connect to this central concern.

First, I observed that the 'psychotherapeutic' – namely, *psychological care* – extends beyond the clinic or consultation room; that some form of evidence-based psychological therapy is now implicated in everyday caring realities beyond clinical contexts. I saw IAPT professionals attending to and enacting caring practices every single day in ways that seemed to surpass

[25] The ethnographic term 'mental health professional' is used here as an umbrella term for the different but related professions featuring in the provision and management of psychological healthcare in the IAPT service: these include first and foremost CBT therapists and other psychotherapists, clinical psychologists, counsellors, and – a new profession specific to the service – Psychological Wellbeing Practitioners or 'PWPs'. The distinction between CBT therapists and PWPs will discussed in more detail in subsequent chapters.

IAPT's conception of 'good' and 'effective' care understood as a set of standardised evidence-based interventions. As a result, we will see here that whilst psychological therapy in the UK might indeed be situated within a so-called medical model of public health, the significance and shape that this form of care has taken is not reducible to nor necessarily always in the service of IAPT and its 'evidence-based' principles. The South London Community Centre in which I did my first period of fieldwork presents us with one such caring reality simultaneously in and beyond the convention of IAPT.

Charities and community centres across the UK are increasingly invested in and entrusted to facilitate services like IAPT. We might think of such places as communities of care. They have become places of 'access' in which perceived hard-to-reach members of the public and other marginal groups deemed most at risk are seen to be more easily reached and provided for. One important point here is that the inventors of IAPT have framed psychological care as a question of 'improving access'; meanwhile, access has been further problematised by IAPT professionals themselves working in communities where such 'access' to psychological care has been deemed lacking. The implication of such communities for the reported success of the IAPT service should not be underestimated. That is, the 'success' of psychological therapies, in IAPT's own terms, is not simply a result of the scientific validation and authority granted to them through the evidence-based framework and strategies (cf. Layard & Clark 2014), but is equally owed to communities of care: the people, spaces, things, and concerns embroiled in caring practices.

We could feasibly argue that IAPT has construed notions of 'psychotherapy' and 'mental illness' in ways that are more familiar within contexts of biomedicine and its appeal to evidence-based medicine. However, instead of being solely a case of biomedicalisation, 'improving access to psychological therapies' has also proven rather more complicated and inventive: IAPT professionals could be said to have enlarged and consolidated the psychotherapeutic in practice to include other modes of psychological care – and caring beyond a medical model. The material in this chapter points therefore to the limitations of theories of (bio)medicalisation/de-medicalisation (see Clarke 2010; Pickersgill 2019a; Yates-Doerr & Carney 2016); we are invited instead to attend to the specificities of what 'mental health' and 'wellbeing' might mean to those engaged in it every working day.[26]

[26] On 'specificities', see Mol (2008); Mol et al. (2010); Vogel (2016).

A medical model

In present-day England, if you are experiencing particular kinds of prolonged distress – for example, being unable to eat and sleep or enjoy activities that one would normally take pleasure in; feeling unbearably stressed or anxious or in despair – there is a reasonable chance that you might be diagnosed with 'depression' or 'anxiety', that is, if you have made an appointment with a General Practitioner (GP). Depending on your GP's assessment of your reported distress, you might be given a prescription for a psychopharmaceutical (such as anti-depressants) – in other words, medication in the form of pills to be swallowed – but you are also likely to be offered some form of evidence-based psychological therapy, commonly known as 'talking therapy'. Even if you have not attended a GP appointment, you might come across psychological services through your workplace, university, school or a charity in your neighbourhood. Today, it is also increasingly likely that you might call a local NHS service and refer yourself on the telephone – or online via one of their websites. The psychological services that you will come in contact with are part of the 'Improving Access to Psychological Therapies' programme.

This is a relatively new mental health service in England which has received worldwide acclaim for its reported evidence-base and effectiveness; whilst it was launched only a decade ago, it has already had millions of pounds invested in it, with the objective of making psychotherapeutic treatment for 'mental health problems' more accessible (cf. Department of Health 2010, 2015; NHS Digital 2018).

According to the medical model at work here, psychological healthcare concerns evidence-based interventions: therapies that have been clinically tested in randomised control trials (RCTs). The now common label of 'evidence-based psychological therapy' is applied to interventions that are understood to have successfully passed through clinical trials through which the 'effectiveness' of the intervention has been verified. Applied to psychology, this model also claims that 'mental' healthcare should adhere to the same therapeutic logic and procedures as 'physical' healthcare (or 'biomedicine'). Features of biomedical care provision often highlighted as central to this medical model include the practices of 'diagnosis', 'disease classification' and 'targeted intervention'. Importantly, the model construes patients as constituting specific diagnostic categories which are matched with specific therapeutic procedures. In other words, the degree and type of 'disease' or 'disorder' are seen to correspond

to a particular degree and type of intervention. This means that when patients are referred to the mental health service of IAPT, they are 'stepped up' or 'stepped down' on a treatment scale according to the diagnosed 'severity' of their reported symptoms. This is usually referred to as the 'stepped-care model' of IAPT.

Medical models or approaches are not new in the discipline of psychology, but they could be said to have undergone a novel reformulation with the introduction of evidence-based medicine (EBM) in the 1990s. EBM has been described as a methodological framework for assessing the effectiveness of clinical practices or interventions (Goldenberg 2006; Lambert et al. 2006). EBM quickly became a scientific convention beyond medicine; it has become constitutive of many aspects of psychological education and practice, for example, but has also prevailed beyond therapeutic arenas, redefining itself in more general terms as 'evidence-based practice' (cf. Trinder & Reynolds 2000).

What counts as evidence-based practice in the UK is now a matter of national assessment and regulation conducted by the National Institute for Health and Care Excellence (NICE), the UK's evidence-based practice advisory board for the NHS. Established in the late 1990s, NICE has become the official executive body under the Department of Health responsible for evaluating and authorising 'health and care' interventions (Dobson 1999), the results of which are published as protocols known as clinical guidelines – or simply as 'the NICE guidelines'. NICE could be said to partake also in an aspect of regulatory objectivity (Cambrosio et al. 2006, 2009) – the collective management of evidence and clinical convention – a topic we return to in Chapter 5. The NICE guidelines prescribe specific interventions endorsed as 'scientifically proven' or 'empirically supported' for a range of specific clinical conditions. Cognitive Behavioural Therapy or 'CBT' is one such intervention prescribed in the NHS through the IAPT service in the treatment of conditions diagnosed as depression and anxiety disorders (Department of Health 2015; NHS 2018). CBT has become a form of psychotherapy so prevalent within the NHS and beyond it that it has largely become synonymous with the notion of evidence-based psychological therapy.

The mental health service of IAPT and the regulatory practices of NICE can both be seen as contributing to a biomedical understanding of psychological care. This medical understanding construes mental ill-health as discrete 'disorders' and classifies patients according to specific criteria that define each disorder. In CBT, a patient's condition is typically described with reference to symptoms classified as 'cognitive', 'behavioural' and 'emotional'. In the IAPT

service, therapists are therefore treating patients who have been diagnosed with specific symptoms of psychopathology. 'Psychopathology' is a word rarely used in IAPT outside clinical or educational contexts and is more often talked about colloquially as 'mental health problems'. What is important here however, is that the IAPT therapist is required to assess the patient's 'problem' as if it were a discrete and observable pathology located in the cognitive interiority of the person. It is assumed therefore that patients are referred to psychological therapy because they exhibit predictable symptoms that correspond to different types and degrees of predefined disorders.

All this means that when a patient undergoes psychological assessment, that patient is asked to report on their experiences and some of these will be classified as 'symptoms' (e.g. 'cognitive distortions) which then determine the degree and type of the disorder already defined in diagnostic manuals (e.g. 'mild', 'moderate' or 'severe' depression). IAPT deploys a diagnostic procedure that relies on self-reporting in the form of patient questionnaires, such as PHQ-9 [9-item Patient Health Questionnaire] for diagnosing depression (see Figure 1). It is thus assumed that patients are referred to a therapist because of distinct mental health problems that can be identified and targeted with treatment, in the same way as a patient diagnosed with a heart dysfunction might be referred to a cardiologist. It follows from this assumption that therapists should assess patients as if they suffered from discrete disorders, just like a cardiologist might assess a patient's heart rate to determine a cardiac disorder.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Figure 1. *9-item Patient Health Questionnaire.*

The anthropological point here is that this medical model of psychotherapeutic care exemplified by IAPT has relied on a physiological reconstitution of 'psychopathology' in which therapists are imagined to detect 'problems' or 'disorders' that are distinct and observable through predictable symptoms which in turn can be treated through targeted intervention. This assumption has become instructive of other areas of care beyond mental healthcare, but it has had profound metaphorical and philosophical import in clinical psychology – approaching 'psychotherapy' as if it were a type of medication to be taken once a week.

Paola was used to this rationale in her own work as a psychotherapist in the assessment and treatment of patients. It was also the implicit presumptions of this rationale that she had alluded to when she had told me how she felt that the medical model 'does not leave a lot of space for people to be contradictory and complex beings'. Paola felt that she worked with a medical model not out of choice but out of necessity: it was apparently 'the only way' to run a largescale public health service. A medical model of care has been widely celebrated (and criticised) for alleviating ambiguity by deploying an exclusively diagnostic approach, promising 'certainty' and 'effectiveness'. But although Paola appreciated the reported effectiveness of this model, she also felt that it compromised other ways of caring – including an acknowledgement of the complexity of psychological distress – that allowed people to 'be human'.

The Community Centre: 'a glimpse of a new community'

The Community Centre where I volunteered was founded in the late nineteenth century as part of the 'Settlement House Movement' and was one amongst other houses in East and South London reportedly founded by graduates from the Universities of Cambridge and Oxford.

When I moved into the Centre, I was told that its early founders had been driven by convictions that 'inequality and deprivation in inner cities demanded a radical response'. The vicar of the local church, 'Father John', as he was known, took me on an hour-long walk around the neighbourhood informing me about 'the mission' of the Centre. He told me how the early founders' conviction of 'a radical response' in the form of 'hands-on community work' owed much to the Christian faith of the time but also how pertinent this vision remains. 'This part of South London still struggles with all the consequences of inequality', he said as we walked through one of the putatively poorest council estates in England. Father John was keen to emphasise the centrality of 'the Church' in the community work of the Centre and its 'shared sense of purpose'. Yet he wanted to assure me that 'community work' went beyond religious

convictions – the work was also 'political', he stressed, in the sense that it worked to improve human welfare for all regardless of 'faith, colour, and culture'.

During the twentieth century, the original 'Settlement House' in the form of the church building had expanded and other spaces had been built to accommodate a growing number of 'residents' in the neighbourhood. Together with the church, other spaces such as meeting rooms, kitchens, a hall, offices and a garden were now seen to make up the 'community centre'. The Centre was led independently from the church by a team of six staff members working together with volunteers. Attached to the original church building was also a Victorian terrace house referred to as the 'Residency'. I was given a room in this house where I lived together with four other volunteers who worked as 'coordinators' of different projects. I had been asked to work as the coordinator of the 'community garden' and its 'wellbeing group'. The job primarily entailed running weekly 'gardening sessions'. We will return to the wellbeing group later.

The Settlement House Movement has been credited historically for inspiring early 'welfare state' advocates in the early twentieth century, most notably William Beveridge (1879-1963) and Clement Attlee (1883-1967) and their plans for a 'cradle to grave' welfare state (Koven 1987). From this came the significant legislation of the National Insurance Act in 1946. Historians have also linked Settlement Houses to late Victorian liberalism and described this 'liberalism' as the source of the early welfare state in Britain. The British welfare state that arose is said to have been shaped most significantly by a 'statism' emerging before and during the First and Second World Wars, followed by the 'universalist' ambitions of the 1940s and 50s (Fraser 1984: 233).

These points are worth noting since the invention of 'community centres' has tended to be analysed solely in light of a 'privatisation' of the national welfare system instigated by Margaret Thatcher's state reforms of the mid-1970s and 80s. Indeed, the Centre sees itself as an example of this history of the welfare state and its decline, and a resulting fight against 'social inequality'. It also shares many of the protestations and aspirations of the 'grassroots' activism of the late 1960s and 70s. The 'welcome' pamphlet I was given when I first arrived in the Centre stated clearly such aspiration:

> We need settlements for the 21st Century: places that offer a glimpse of a new community—where residents, local groups and organisations co-operate to build a better neighbourhood.

In addition, staff members also told me how the more recent restructuring of the NHS, together with the introduction of further 'private sector' involvement prompted by the Health and Social Care Act 2012,[27] had steered the provision of public health services further into a reliance on charities and other non-governmental organisations (NGOs). I was provided with several figures from statistics and other research that ostensibly confirmed the distressing consequences of these changes (e.g. Garnett et al. 2017). For example, the council estates surrounding the Centre had recently been estimated to fall 'within the bottom 10% most deprived nationally'. Research had also estimated that a third of the children in the neighbourhood 'live in poverty' (e.g. Fonagy & Clark 2015). I was likewise informed that the area had seen some of the highest levels of 'social isolation' amongst the elderly. 'This part of London remains an area of stark inequality', asserted the Director of the Centre in my first meeting with him. 'Most residents in our community live well below the poverty line next to expansive new developments crowned by multi-million-pound penthouses.'

Circumstances of inequality were frequently explained to me and were seen as the result of the local government's 'gentrification' or 'urban restructuring' policies, involving most significantly 'real estate development' with the effects of 'community displacement'. These experiences often resolved into a logic and language of exclusion/inclusion (Candea 2010) mobilising common categories of critique. The issues identified – for example, 'homelessness' or 'lack of access to healthcare' – were variously defined, contextualised and criticised with reference to 'politics' and 'economics', 'society' and 'culture'. A 'crisis' in public healthcare was thus broadly felt and experienced by those living in this part of South London, and similar accounts are not uncommon in the UK (see e.g. Exworthy et al. 2003). A perceived 'mental health crisis' has entailed and elicited criticisms of the ostensible causes and effects of such a crisis. These are points we return to later.

The mental health professionals working in and around the Centre described their job as concerned with 'the local community', with people who have little means to get by, with single parents or new mothers or lonely neighbours, including the elderly, the sick and the marginal. The Centre housed different activities and organisations: it had a popular church choir originally started by people who had been homeless or addicted to drugs or alcohol,[28] a dance

[27] See http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted [accessed January 2019].

[28] On the question of alcoholism, drugs and addiction, see McDonald (1994) and Weinberg (2011); for commentary on homelessness in Britain, see Anderson (1993) and Bretherton et al. (2013).

and music academy for children and young people, a tutorial service for families unable to afford tutoring or unable to help their kids with homework, as well as an in-house educational organisation encouraging and assisting sixth-form students to apply to university, lunch clubs for the elderly, and much more.

The Centre actively seeks, in its own terms, to celebrate diversity, community and face-to-face interaction in a context of increasing social alienation and impoverishment. The people working in this Centre see themselves as trying to make a difference in a part of London which was described to me as 'an extremely deprived area socio-economically', but also 'very multi-cultural' – the latter a positive feature to those who worked in the Centre. The older generations of the community were described to me as 'White British' South Londoners. Many of them had grown up and lived in the same neighbourhood all their lives, witnessing the Second World War as children, the introduction of social housing in the 1960s and 70s as young adults, and then a 'slow decline' of neighbourhoods, as some residents described it, into 'ghettos' and then suddenly, it seemed to them, a rapidly transforming 'gentrification' over the past ten years. When I moved to the neighbourhood, many of the old housing estates had already been sold by the Council to private developers. The large concrete blocks had been demolished over the past decade and replaced with 'sleek brick-and-glass buildings with balconies and gardens that only people with money can afford', as one of the residents put it. 'The locals are losing their homes', a volunteer of the Centre observed. 'Families are being pushed out of South London', another resident told me. 'I am losing my home and my family has lived here for generations. The community is falling apart.'

In the UK and elsewhere, common understandings of 'community' align with other conceptual titans, not least the concept of 'culture'. The idea of 'community' was born of romanticism (Chapman 1978; Anderson 2006 [1983]) and has, much like 'culture', largely become part of people's apperceptions in Europe and beyond (Bauman 2000; McDonald 2012b). It tends to evoke geographical or typographical properties and boundaries, together with perceived commonalities: a community might have its own 'identity', 'language', 'ethnicity' or simply 'people', indeed its own 'culture'.

'Gardening for Wellbeing'

When I moved into the Centre in the summer of 2016, it had recently set up a 'wellbeing programme'. This was an initiative supported by the local Council and NHS Trust[29] as it was seen to align with IAPT's sustained efforts to raise awareness of 'talking therapies'. Whilst the Centre itself did not offer psychological therapies – it was not part of the NHS – nor did it identify as a mental health charity, 'wellbeing' was nevertheless something to be improved according to the managing staff, the volunteers and community workers. It was not obvious to many people however, what exactly 'wellbeing' might entail or how it might be achieved or attended to. It was open to multiple (sometimes conflicting) interpretations and imprecisions, but this ambiguity seemed also to underscore the importance of the term. Wellbeing is a concept that has become reified increasingly over the past twenty years as an object of expertise and investigation from economists and psychologists to philosophers, sociologists and anthropologists. The recent invention of a self-defined 'Science of Wellbeing' attests to the contemporary popularity of the notion (see Alexandrova 2017).

Key to the Centre's efforts to run a wellbeing programme was the 'community garden', a so-called 'urban garden' set up in the old parking space and courtyard. I became a volunteer coordinator of the community garden, hosting weekly gardening sessions for residents, especially for people diagnosed with mental health problems or for those considered 'isolated' and 'lonely'. Usually, five to ten people would attend these sessions which lasted three or more hours in the afternoon. A typical session involved drinking tea and coffee, catching up and talking about someone's life or whatever came up; sometimes we discussed the Centre's many activities and events or any appointments that the participants had attended. All of this took place around and through the practice of gardening.

Gardening, like cooking (Yates-Doerr & Carney 2016) or farming (Mol et al. 2010), could be said to be a practice of *caring*. Gardeners attend to the weather, the soil, seasonal changes, and much more; they plant, water, weed and cut; compare, smell, touch, taste, watch and wait; they experiment with growing different herbs, vegetables or flowers, and attend to their environment. Gardeners, in other words, take care of a garden.

This was the logic of the community garden when it was set up about ten years ago. People were growing vegetables and flowers out of discarded plastic boxes. 'Urban gardening' was the

[29] The South London and Maudsley NHS Foundation Trust (SLaM).

term coined for these green oases and pocket gardens surrounded by concrete, steel and stone. The summer I began volunteering, the community garden had just received funding from a local charity to renovate the outdoor space and make it more 'user-friendly'. We spent several weeks removing the old plastic boxes as we started building stationary wooden vegetable and flower beds instead. We dug up the former car space, planted grass where there had been concrete, and installed a small shed (for rainy days) and a kitchenette for cooking and coffee-making. The staff in the Centre deemed it a green haven for the elderly, the sick, the lonely, the poor, and the mentally ill: 'for people in need of a caring environment', I was told. We were all 'gardening for wellbeing'.

It was during my first summer of living in the Centre that I met Paola, a psychotherapist in her 40s, whom I introduced earlier in this chapter. Paola was passionate about 'making a difference' in this area of London and had been funded a position by SLaM (The South London and Maudsley NHS Foundation Trust) as a 'community worker'. It had initially been difficult to convince SLaM of the importance of such a position, she told me. However, since community centres were also considered important sites as the public face of 'access' to public healthcare, Paola had successfully argued that 'working in the community' was crucial to reaching people deemed to have little or no access to psychological therapy.

With Paola's assistance, I ran the gardening group. The Centre's idea behind 'gardening for wellbeing' was that it provided a more intimate setting and opportunity 'for getting to know people in need of care'. Paola and I listened to people's life stories, their ideas and worries; many were seeking some form of help with self-reported 'mental health problems', and some had difficulties finding or making sense of 'the services'. Some concerns revolved around types of financial difficulty expressed as debt, cuts to social benefits or struggles with tenancy and rent increase. Most participants in the wellbeing group presented themselves with a diagnosis of mental illness; a few had previously been hospitalised and others had been in and out of psychiatric services for years. Others told me about their process of 'recovery'. Recovery often meant that people had been declared 'fit to work' and to 'take care of themselves' (some indeed felt they had 'recovered', but others did not). This was a language of 'mental health' and 'mental illness' that the participants themselves conveyed, and many were familiar with psychiatric or psychological terminologies relating to the diagnosis and symptomatology of their own reported conditions.

When Paola started working in the Centre in her position as an IAPT therapist, it had become clear to her that 'many people aren't getting the right kind of care, or have difficulties accessing it'. Derek, for instance, a man in his 50s, had been diagnosed with schizophrenia in his early 20s. He had lived in the borough all his life, been in and out of psychiatric in-patient units and, when I met him, had recently 'made a home out of a room in an old factory building', as he put it, because he was unable to afford his flat after his benefits had been cut. Derek had attended the wellbeing group's gardening sessions for over a year and had taken up creative painting classes offered by another charity. He told me how painting had had a positive effect on his 'mood and mind'; he was now more likely to sleep for an entire night instead of a few sporadic hours that he was otherwise used to. Through the Centre's Wellbeing Programme, Derek had also been offered weekly psychological therapy in IAPT which he felt had helped him greatly in dealing with his emotions, especially the manic, uncontrollable outbursts that he said would paralyse him for days. He felt that talking therapy allowed him to come to terms with aspects of his life that still haunted him.

Many locals like Derek had come in contact with the IAPT service through the community garden or by being involved in other activities organised by the Centre. People like Derek were therefore one of the main reasons why Paola saw the gardening sessions as a means to help locals get 'the right kind of care'. The Centre sometimes provided this care in the form of other engagements: lunch clubs for the elderly, for example, or the Alcoholics Anonymous choir. At other times, the right kind of care meant accessing public health services, such as IAPT's programme of psychological therapy. The weekly gardening sessions were thus part of a collective effort to improve not only access to IAPT (that is, evidence-based psychological therapy) but also an ever sought-after 'wellbeing'.

Although our sessions were referred to as the 'wellbeing group', I had been instructed that they were explicitly not part of an official mental healthcare service or pretending to provide therapy in any shape or form; instead, they offered a way in which participants could access such professional services if they wanted. However, for the mental health professionals involved, 'gardening for wellbeing' was still part of a process of psychological care. 'Yes, talking or gardening is not psychological therapy, but these meetings are still *therapeutic* for many of those who attend', Paola asserted after one of many long days spent gardening. Improving access to IAPT turned out to be less straightforward than its founders had envisaged (Layard and Clark 2014), but also far more 'caring' than the anthropologist had anticipated. We were

undoubtedly no longer in the clinic. We were in 'the garden'. We were gardening for wellbeing and cooking up 'health' (see Yates-Doerr & Carney 2016).

Improving access to IAPT

When economist Richard Layard and psychologist David Clark introduced their plans for a new mental health programme in the early 2000s, it was widely promoted as a commitment to 'improving access to psychological therapies'. This idea was deemed so fundamental to the programme that it became the official name of the service when it was launched as part of the NHS in 2008. In Chapter 3, we return in more detail to the features of the programme itself. Before we arrive there, we will be looking at how IAPT took shape around two important inventions: the category of 'depression' and the practice of 'self-referral'. Depression and self-referral have been construed, respectively, as obstacle and solution; we turn first to the question of access which has been problematised with reference to both.

Problematising access: 'depression' and 'self-referral'

In the promotion of IAPT, Clark and Layard argued that a lack of access to evidence-based psychological therapy had resulted in a mental health crisis in the UK (see e.g. Layard 2005a; Clark et al. 2009). In other words, people categorised as suffering from 'mental illness' were construed as being 'cut off' from services or otherwise lacking mental healthcare because of public health infrastructures that limited access to psychological interventions.

'Depression' has been, and remains, the central category of 'mental illness' evoked here. We could say that 'depression' has been reified, through the invention of IAPT, as a discrete psychological pathology that should be treated primarily through evidence-based psychological therapy. Importantly, documents such as 'The Depression Report' (The Centre for Economic Performance 2006) asserted that 'depression' could be accounted for in terms of its economic costs, a claim that further reified the category as a significant object of economic concern and expertise. Sociologist Martyn Pickersgill has suggested that the design of the IAPT programme relied on an *economic* problematisation of 'depression' which structured not only the way in which Layard lobbied the Government but also the programme's subsequent implementation (Pickersgill 2019a: 633). Elaborating on this point, we might also note that it has been through the language of economics – in particular, 'happiness economics' (Layard 2005b) – that Layard

and Clark have continued to justify IAPT to its critics (e.g. Layard & Clark 2014). They thereby rendered its 'success' *quantifiable* within a cost-effective framework. Within this framework, calculations of the reported economic burden of public mental healthcare also justified psychological therapies rather than psychopharmaceuticals such as antidepressants (Layard et al. 2007; see also Layard & Clark 2014).

The economic problematisation of not just 'mental illness' but of an allegedly nationwide mental health crisis, epitomised by the category of 'depression', has elided into an economic justification for psychological therapy spearheaded by CBT. As such, the proposed 'solution' to the reported crisis of mental illness was therefore not simply deemed to be a matter of establishing the most effective intervention (e.g. CBT or antidepressants, or combined treatment) but rather a matter of *access* to such interventions. 'Access' was thus systematically problematised by Layard and Clark to persuade the Government to introduce a new model of provision of public mental healthcare within which psychological therapy could assume a central position. If 'psychological therapy' was the solution to the problem ('depression'), then 'improving access' was the conceptual means by which it could be achieved.

However, what exactly 'improving access' entails or requires, in practice, has been left relatively unquestioned. Clark and Layard argued early on that improving access to psychological therapies could be accomplished through a new procedure of 'self-referral', complemented by conventional patient referrals issued by GPs. Today, self-referral is considered to be the primary way in which people access IAPT.

Self-referral has generated its own problems, however. One problem has been that the practice of self-referral assumes and relies on the idea of the self-determining individual capable of self-inspection and self-report. These might seem like rather innocent human features, but their implicit assumptions have proven tremendously problematic in public care: from the very notion of 'the individual', to this individual's capacity to choose and make informed decisions (see e.g. Strathern 1995; McDonald 2010; Reubi 2012). Self-referral can thus be seen as an explicit instantiation of a 'logic of choice' (Mol 2008) owed to a relatively new formulation of 'patient choice' which has informed health policymaking in the UK and elsewhere (Greener 2009; Mol 2008). In mental health conferences, I watched presenters (mostly policy-makers and service commissioners but also practitioners) discussing topics related to the concept of patient choice, with many asserting that patients should be allowed to be in control of their own care: 'they have a *choice* after all'. Such discussions and their wide

dissemination across public services have helped construe people as choosing agents in charge of their own 'mental health' – to 'take care of yourself' – but also rendered patients further into (ac)countable subjects. Referring your 'self' to a service might require one to take up a particular subject position, in which 'mental health' is not only something one 'has' but is something that constitutes the very notion of 'our selves' (Rose 1989, 1996). This position assumes a self in charge of itself, so to speak.

Of course, we might likewise say that choosing and self-determining selves are precisely what 'good' care is supposed to be about: patients should be allowed to have a will and a choice in letting other people care for them and in caring for themselves. Self-referral is thus one important practice confirming the ideal of care as choice and agency over oneself; 'it's good practice', some practitioners told me, 'it's ethical'. These are concerns familiar also to the anthropology of ethics (e.g. Faubian 2011; Laidlaw 2014) and, more recently, an anthropology of 'the good' (Fischer 2014; Robbins 2013). Anthropologists working in these fields in relation to mental health have often tended to locate 'the ethical' in practices described as 'self-care' (see e.g. Yates-Doerr 2012; Nissen 2015; Cook 2015; Vogel 2017; McKearney 2018) drawing on the Foucauldian legacy concerned with ethics as 'the care of the self' (Foucault 1988; see also Moore 2011 and Laidlaw 2002). However, anthropological framings of 'care' and 'the self' have to be wary of not simply re-instantiating ethnographic assumptions that are also built into Foucault's ethical selfhood. We come back to this point in Chapter 6. What I want to suggest for now is that IAPT's promotion of self-referral forms part of the proliferation of a range of emerging practices in the UK framed as in the service of 'self-care'.

'Working in the community'

When I started working with IAPT professionals at the community centre in London I quickly learned however that questions of access were problematised further internally amongst professionals within local IAPT services and by local authorities commissioning the services. Despite the reported acclaim of the implementation of 'self-referral', for many IAPT professionals, relying on 'self-referral' seemed nevertheless an inadequate notion for 'improving access'. I found out later in my fieldwork that calls for 'working in (and with) communities' were often raised and discussed on panels at IAPT conferences and in meetings with NHS Trusts and Clinical Commissioning Groups (CCGs). Raising awareness of self-referral amongst people deemed to be 'cut off' from mental health services, as many argued,

was indeed seen as part of what 'working in the community' might entail. However, other therapists working in IAPT do not assume that access is simply achieved by adding 'self-referral' to the infrastructure of public mental health, as Layard and Clark claim.

Important aspects of Clark and Layard's ambition seem yet to be realised. One day when I was with Paola in the office, I commented on the slight irony of her role: she had been employed to improve access to the *Improving Access to Psychological Therapies* service. She admitted it seemed slightly absurd but explained that the IAPT service, in spite of 'its extensive integration in the NHS across the entire country' was still struggling to provide 'psychological healthcare to communities considered most in need of such care'. The 'communities' deemed to have little or no access to public health services had been identified as 'low-income', often 'ethnic', with 'high levels of unemployment' and 'social deprivation'. The neighbourhoods of South London in which the Centre was based were generally regarded as one such example of lack of access to mental health services.

Once I got to know the area better, I realised that the 'communities' in this area of London, to which Paola was referring, are only a ten-minute bus ride from the South London and Maudsley Hospital (SLaM) located in Denmark Hill. SLaM is one of the largest and most distinguished NHS Trusts in the country (headed by the Maudsley Hospital with several departments under the University of Kings College London, most notably the Institute of Psychiatry, Psychology and Neuroscience). It is also important to note that the Maudsley Hospital and the Institute of Psychiatry formed the birthplace of a specific 'laboratory-' and 'research-based' psychotherapeutics in the form of behavioural therapies in the 1950s. This historiography seems to have been largely eclipsed by IAPT's own historical self-celebration as 'new' and 'novel' in all aspects of its own invention, in which it has drawn up for its own purposes a recent historical past in which the 1990's movement of evidence-based medicine (EBM) and Richard Layard's 'happiness economics' of the early 2000s feature as historical forefathers. However, the much earlier clinical work and research of the Maudsley Hospital and the Institute of Psychiatry could be seen as a precursor to the institutional practice of, and indeed the very notion of, 'evidence-based' psychological therapy.[30]

The issue appears to be that, despite its extensive and much-lauded institutionalisation, IAPT has still not, in its own terms, been successful in 'accessing' many communities deemed

[30] For a fuller account of this historiographical point, see Marks (2015).

most in need of its mental health services. This was a point raised repeatedly during my fieldwork. The 'mental health services' and 'the communities' in question were often discussed as being far apart despite their geographical proximity: many services were practically located right in 'the community' they sought access to. I was surprised to learn in meetings with IAPT professionals that one of the central objectives of IAPT to secure public psychological healthcare for those deemed most in need was a commitment that these professionals still had to negotiate and defend within the context of IAPT itself. For Paola, it was only after a period of difficult negotiation with the regional NHS Trust, her employer, that she had finally been granted a position 'to work in the community'. Paola told me about this triumphantly: 'You see, access to mental healthcare requires more than just policy-making and the commissioning of services. It is the actual work done on the ground which improves access to IAPT.' Paola shared this conviction with many other IAPT therapists I met. For them, 'improving access' meant working in the communities themselves; engaging people face-to-face; educating those who have never heard of the concept of 'talking therapy', let alone 'IAPT'; collaborating with and across other public health services beyond the stipulated interests of one's own specialist provision of care; and very much more.

Paola and her colleagues had explained to me that the 'work done on the ground' meant understanding 'user experience'. This involved trying to take account of the 'real needs' as well as the 'social context' and 'cultural environment' of those people reportedly lacking access to psychological therapy. Such a shift in concern was not only important to the IAPT therapists I worked with in London but was also noted increasingly in professional conferences on mental healthcare that I attended. These practitioners were thus working to contextualise and locate their own practices. What had initially been promoted as a near-universal and uniform public service (cf. Layard and Clark 2014), now had to take account of its own contextual operation. As a result, the IAPT programme is now more commonly discussed amongst practitioners as consisting of *local* services, each having to respond to its own 'local community', its 'people' or 'users', and their needs, problems, and experiences.

Working in, or with, 'the local community' turned out to revolve around the concept of 'co-production', a notion which has become increasingly widespread in discussions of public service provision in the UK (Barnes et al. 1999; Glynos & Speed 2012). Co-production is often described as a way of working together to produce 'user-led' and 'people-centred' services pertinent to a range of disciplines and institutions from hospitals, museums and schools, to

architecture, psychiatry and development studies. Co-production was a hot topic in almost all professional conferences I attended in which questions of 'access' and 'improvement' were on the agenda. The term is said to have been coined by American economist Elinor Ostrom in the late 1970s to describe a process of collaboration between 'users' and 'providers' in the assessment, management and delivery of public services (Filipe et al. 2017). Ostrom argued that the viability of any 'public service' depends on direct interaction with, and understanding of, 'the community' in which it seeks to operate (Ostrom 1996). Although 'co-production' seems to have become mainstream in the UK in government, research and public policy discourses especially (Jasanoff 2004), it has nevertheless been described as one of the most radical approaches to NHS reform (Malby 2012).

In relation to IAPT, co-production can be summarised as challenging the idea of patients on the passive receiving end of mental health services. The concept frames instead patients as 'users': people *use* services and are seen to be embroiled in an active evaluation of them. In conferences on NHS mental health services, the language of co-production was thus used to radically reframe the role of 'patients' as 'service users', often presented as a way to rethink the process of providing care. 'Service users' and also 'communities' were understood and discussed here as important agents with the capacity to collaborate with practitioners in the design and improvement of mental health services. Co-production thus provided a meaningful language through which mental health practitioners felt more engaged with their patients; rather than viewing patients as passive recipients, they were understood as taking active part in the production of their own care. This language also captured what many IAPT therapists felt was the inherently 'collaborative' quality of psychotherapy: some felt it put the 'relationship' back into the practice of psychological care.

Paola had thus been hired in part to improve access to the IAPT service in communities that local authorities had identified as 'difficult to reach'. With funding from the borough's Clinical Commissioning Group (CCG), she and other mental health professionals had managed to set up a 'Wellbeing Hub' to improve access to relevant healthcare services by putting residents in contact with providers, assisting them with referrals or appointment, informing them about available services, and so on. 'Finding the right support and care can seem complicated and overwhelming for many people', Paola had told me in our first meeting. As part of the Wellbeing Hub's 'outreach', she had started a 'drop-in' service at the Centre; 'This service is for anyone living in the area who is worried about their wellbeing or that of someone close to them.'

The Hub also included an online directory of organisations intended to help 'signpost' services, thus assisting health professionals to navigate between them in providing the best support to people in need of care. When I asked Paola why the Wellbeing Hub had been deemed so necessary, she told me that access to care is a process that needs to be simpler. Bringing services together and the people who run them was crucial to this aim.

Linked to the aim of signposting was another initiative called the 'Wellbeing Network'. It was set up to provide a forum for the service providers and service users of the Wellbeing Hub. The Network met once a month to discuss different issues, share experiences, give presentations, and so on. Paola's intention was to bring organisations such as charities and NHS services into direct contact and conversation with each other, engaging both professionals and carers as well as service users. The Centre hosted the monthly meetings and they were quickly considered quite an achievement with over thirty representatives from healthcare services and charities attending every month. I attended these meetings for over a year, gaining access by representing the Centre's wellbeing group in my role as a coordinator, as well as in my open role as an anthropologist engaged in research on mental healthcare. The Wellbeing Hub and the Wellbeing Network were widely felt to link the original efforts of the 'settlement house' to the contemporary ambitions of a 'community centre'.

Care beyond IAPT

As we have seen, the South London community centre has become a context for 'improving access' to evidence-based psychological therapy. But while it has certainly participated in IAPT's vision of improving access to psychological therapies, it has done so by attending to 'mental health' and 'wellbeing' in ways that no longer hinge on questions about the scientific status of the interventions deployed. In fact, the language of 'intervention' or 'effectiveness' – and other cognate notions owed to the putative 'medical' model of care – is largely absent from the psychological care pursued in and around the Centre by the mental health professionals I worked with. Rather, it is the potential 'caring' capacity of any activity and concern relating to 'mental health' that they foreground. This is partly why the Centre was able to align a range of seemingly different activities and concerns with a common aim to care for the 'wellbeing' and 'mental health' of its residents. Gardening, singing, cooking, and dancing, or doing CBT sessions on a computer, talking to a therapist, running for charity, selling marmalade at the annual community festival, volunteering, and so on, were part and parcel of the same world of

caring practices. Indeed, it is perhaps the persisting ambiguity of the notion of 'wellbeing' which has assisted such alignment.

The Centre's community garden and its wider wellbeing programme were therefore not intended to provide psychological therapy per se, although it was talked about as a 'therapeutic' space. The garden was intended instead to offer an informal 'pathway' for people who were said to be 'out of reach' from healthcare services to better 'access' the care they need. Accessing psychological care was not, however, a straightforward case of being referred by a GP or by one's 'self'. Rather than attending to people as individual clinical subjects (as would be the case in the psychotherapeutic consultation room), daily care practices in the Centre sought to address all the shifting and diverse circumstances that were seen to constitute 'mental health' and 'wellbeing'. Psychological care emerged therefore not simply as a matter of passive clinical subjects being on the 'receiving' end of a 'delivery' line of care provided by active professionals. Even 'patients' act and enact in the process of caring for themselves: they swallow pills, for example, or talk about their past, book appointments, attend appointments, fill out questionnaires, practise exercises, techniques and inspections, and so on. Patients are not just intervened upon but are actively engaged in the 'enactment' of care (cf. Mol 2002). These issues have been explored elsewhere in anthropology (see Mol 2008; Lynch & Cohn 2016; Pols 2012; Yates-Doerr 2012), but what seems important to highlight here is that psychological care called for concerns, relations and engagements with the context at hand in which there was no prescribed 'evidence-based' procedure to improve 'access' or 'mental health', with neither 'the patient' nor 'wellbeing' pinned down as stable objects of scientific enquiry.

Other forms of care beyond psychological therapy (as envisaged by the IAPT programme an undergirded by the regulatory practices of NICE) were thus constitutive of IAPT professionals' efforts to improve 'mental health' and 'wellbeing'. For example, the concept of 'diagnosis' or the category 'cognition' are fundamental to psychological therapies such as CBT, and yet neither did 'diagnosis' nor 'cognition' necessarily figure as relevant in the caring practices of IAPT therapists when 'working in the community'. If it seemed difficult for the professionals to make the language of CBT (or evidence-based therapy more generally) workable outside the clinic, it was not because of a lack of 'access' but rather because problems identified in clinical contexts quickly became entangled with circumstances beyond those which evidence-based practice presupposes.

We might be tempted to conclude that 'access' has been envisaged and provided by IAPT according to a medical model in which 'self-referral' assumes the ideal of the autonomous human subject; an individuated 'user' capable of reflecting and reporting on their own self; informed to make decisions with a will and a choice. And further, equipped with such a model of the patient, IAPT could be said to have contributed further to a medicalisation of mental ill-health. However, as we have seen, access to IAPT and the provision of psychological care have also relied on modes of caring which go beyond medicalisation or a medical model of care.

Beyond common divisions

The IAPT service might appear then to have been designed according to a medical model of care, and it is within this model that IAPT still seems to operate and provide CBT specifically and psychological healthcare more broadly. Yet the ethnographic reality of the Community Centre shows how caring practices often traverse the clinical contexts that gave rise to them. IAPT's vision of psychological therapy in the form of CBT (and other CBT-based interventions) is not always what is deemed to be workable or conceivable when we move beyond the psychological consultation room. In and around the Centre, the language of 'evidence-based psychological therapy' or 'CBT' was at once confirmed and negated. IAPT's notion and practice of psychological healthcare as consisting of a specific set of evidence-based interventions (that correlate with discrete types and degrees of 'mental disorder' or 'mental health problems') have been difficult to enact outside IAPT's clinical contexts – wherein psychological therapy is highly standardised and manualised – because this model of care fails to allow people, as Paola put it, 'to be contradictory and complex beings'.

On the contrary, it was communities such as the South London Community Centre which have allowed people 'to be human', according to the mental health professionals, because they put conceptions of 'care' and 'wellbeing' into practice beyond a perceived medical model. We could then be tempted to theorise community centres of this kind as constituting a process of 'de-medicalisation', in common with recent anthropological studies of care practices beyond clinical contexts (Yates-Doerr & Carney 2016), or, some form of opposition to medicalising structures and rationalities (see e.g. Vale 2012; Wright et al. 2018). However, there was no straightforward de-medicalisation of 'mental illness' and 'mental health' involved in all of this. For example, it was not unusual for the community garden's participants to talk about their 'mental illness' as if it corresponded to discrete disorders located in 'the brain' or 'the mind'

and which would eventually yield to the right kind of drug or talk therapy. There was no easy way out of the assumptions built into the medical model that IAPT in many ways seems to have revivified. One such assumption has been the metaphorical 'pill': the notion of medication was instructive of how 'psychotherapy' or 'talking therapy' was framed and made sense of: something to be 'prescribed', 'applied', 'taken'. In other words, it appeared that the IAPT service had contributed to a medical model of the 'psychotherapeutic' (as it figures in the form of CBT) whereby psychological therapy has been stabilised as a set of consistent and fixed techniques – *as if* it was prescribed medication. The problem was, however, that getting well through psychological care was nothing like swallowing a pill. We return to this pervasive metaphoric in Chapter 5.

The IAPT service and its formulation of psychological therapy might thus be described as having reified notions of 'mental health' and 'mental illness' within a largely medical model of ill-health (see also Pickersgill 2019a), often adhering to the language of neuroscience and a biological psychiatry rather than its own psychotherapeutic (especially 'psychodynamic') heritage (Bruun 2014; Marks 2015). However, the caring practices of mental health professionals that take shape around these notions are not always in the service of IAPT's scientific persuasions. IAPT therapists might work, in their own words, to 'improve access' to psychological therapy but the daily work required to do so involves concerns and caring beyond that envisaged and accounted for by the IAPT service. The clinical objects of concern in IAPT – the patient, the disorder, the mental health problem – are rarely what IAPT professionals end up dealing with when 'working in the community'. The category of 'depression', for instance, did not always offer a pertinent language in this context, nor did the notion of 'self-referral', although both have been fundamental to IAPT's construal and problematisation of 'access'.

Anthropologists studying the professional work of psychotherapists have often delineated the 'psychotherapeutic' in opposition to the 'biomedical' (cf. Luhrmann 2000; Davies 2009; Calabrese 2013). Yet, the ethnographic reality of IAPT might serve as an analytical break against a common bifurcation of the psychotherapeutic and the biomedical as opposing scientific epistemologies and modalities of care. Another common division in medical anthropology has been between processes of '(bio)medicalisation' (Foucault 1973; Lock & Gordon 1988; Canguilhem 1989; Clarke 2010) and, by contrast, those resisting medicalising practices and logics (see e.g. Harvey 2008; Luhrmann 2000; Davis 2012; Yates-Doerr 2012; Cook 2016) including its governmental implications as outlined in the works of Foucault

(1991), Rose (2006), Hacking (1991) and others. But situating care practices – and psychological therapy in particular – along the lines of this conceptual division might not always be helpful.

So, whilst it could be argued that the Community Centre represents a case of 'de-medicalisation', this sort of theorising runs the risk of construing the IAPT service – and specifically the work of IAPT professionals – as a direct resistance to the prevalence of biomedicine; such a conclusion would be misleading. On the contrary, suggesting that IAPT is in the service of biomedical rationalities does not adequately capture or acknowledge the shifting and diverse concerns and caring practices of so many IAPT professionals working to improve mental health and wellbeing in communities where psychological therapy has been introduced. If we fail to attend to care outside the conceptual framework of either medicalisation or de-medicalisation, we have failed to appreciate a great deal about what psychological care means to many mental health professionals.

The case of IAPT is one such ethnographic reality which could be said to simultaneously engage a medical model of ill-health and care *and* reinvent it by encouraging other forms of care beyond a clinical context and rationality. It remains that the founders and advocates of IAPT, as well as the practitioners working in the service, frequently asserted that a medical model was 'the only way' to provide psychological healthcare on a 'national scale' and 'as part of the NHS'. And yet, providing access to psychological therapy emerged as different modes of caring practices that were not exclusive to such a model and indeed traversed it. 'Mental health' and 'wellbeing' took on different meanings and mores in and around the Centre; indeed, the aim of improving access involved active engagements with potential patients beyond '(self-)referral'. Through glimpses of the modes of caring practices that unfold in the South London Community Centre, we saw that IAPT therapists' aim to improve access is not contained in any one particular practice, and further, that accessing psychological healthcare does not always necessitate the use of evidence-based psychological therapy nor align with IAPT's conception of psychological care as standardised and measurable in compliance with the principles of EBM and the NICE guidelines.

The community garden was thus enacted as a mode of (psychological) care. 'Gardening for wellbeing' did not hinge on any ideals of the 'individual' sought through self-referral nor did it instantiate mental health problems as discrete disorders but, rather, we might say that it put relationalities into practice, involving more than human carers (cf. Cohn & Lynch 2018):

plants, seeds, sunny days, coffee and soil were all part of a caring relationality. Likewise, participants were brought into new relationalities through the community centre at large and beyond: at times this resulted in CBT sessions at the local IAPT service; at other times not. The mental health professionals felt that the community garden acknowledged – and perhaps served as a reminder of – the therapeutic 'relationship' in psychotherapy, even if gardening was not psychotherapy; it allowed people to be 'human', in Paola's words. It also reminded the anthropologist of the inherent relationality of 'care' itself.

chapter two

Psychotherapeutics

A brief history of psychotherapeutics

This chapter takes us into some historical contexts that have been important in shaping 'mental healthcare' and the more recent invention of evidence-based psychological therapy. This historiography cannot be dealt with in full in this thesis; I have sought instead to draw attention to particular aspects of what professionals might recognise today as 'mental healthcare' in Britain, that in one way or another have laid the grounds for the much later invention of the IAPT service. Some of these points have been well-rehearsed elsewhere by historians (as references in the text suggest).

It also seems important to note here that the historiography of psychology and psychotherapy is a contentious one with more histories written by practitioners themselves than by professional historians (such as Ehrenwald's famous book from 1976, titled *The History of Psychotherapy*). More recent attempts to write 'the history' of clinical psychology seem to have been similarly inclined. For example, at one of the conferences I attended, I met Sarah Marks, an historian of psychology, who told me how she had been gradually excluded from the editorial position first granted to her in what was proclaimed to be the first historical volume on clinical psychology in Britain published by the British Psychological Society [BPS] (cf. Hall et al. 2015). Marks nevertheless published two chapters in this volume, but her efforts to bring a critical editorship to the book as the only professional historian were largely dismissed (Marks was subsequently removed as one of the editors of the book when it was published in December 2015; ibid.). Other historians of psychology I met reported similar difficulties in their research and publication projects. Historian Rachael Rosner, for instance, had long tried to write a historical biography of the founder of Cognitive Therapy, Aaron Beck, but had repeatedly been denied access to important archival material in the possession of psychological institutes claiming to support historical research (see Rosner 2012).

A brief but important excursion into history and historiography, I feel, will aid comprehension of my ethnographic work. I concentrate here on the period of the nineteenth century up until the mid-twentieth century in situating a history of psychotherapeutics within the development of medico-legal structures such as 'the public asylum' and 'the mental hospital'. Each of these provided a definitional context against which a 'national mental health service' was consequently conceived and constructed – and through which the IAPT service later emerged with its own notion of public psychological healthcare.

Following other scholars of the 'psy' disciplines (see e.g. Marks 2018), I use the term 'psychotherapeutics' here in an attempt to encapsulate historically contingent forms of psychological therapeutics that might not always be thought of as 'psychotherapy' as present-day mental health professionals use the term.

From the asylum to the mental hospital

The public asylum in Britain developed within the legal framework of the Poor Law of 1834, a revision of the Elizabethan Poor Law of 1601, with its carceral structure in the form of 'workhouses' (Unsworth 1993). Workhouses were set up to provide 'indoor relief' for 'paupers' throughout the nineteenth and early twentieth centuries. During this period, the public asylum became the primary institution of mental health intervention across Europe founded on a legalistic and custodial approach to madness which had defined its institutions since the seventeenth century (Foucault 1961). The institutionalisation of asylums as centre points for the treatment of the 'mentally ill' had initially been founded on 'reformist' and 'therapeutic' values. However, during the nineteenth century, and up until the early 1930s, British asylums appear to have been characterised by a highly custodial management of patients which seems to have involved little or no 'medical' or 'psychological' treatment (Unsworth 1993). Rather, the custodial nature of the asylum could be seen as protecting the 'liberty of citizens' (including doctors and psychiatrists) from 'dangerous' patients through practices of confinement. According to some historians, this was a rationale epitomised in the Lunacy Act of 1890 (Busfield 1998).

It was partly through the political work of Liberal Governments of 1906-1914, which introduced reforms into public welfare, that the principles underlying the treatment of 'mental disorder' and 'the insane' began to shift away from custodial models of treatment. It was in many ways the outbreak of the First World War that challenged the asylum system and its Victorian orthodoxy. The emergence of 'war trauma' amongst citizens, especially soldiers, challenged legal assumptions about the appropriateness of compulsory detention in particular and the role of asylums in general (Jones 2004). During and after the First World War, numerous soldiers returning from the war suffered from the effects of what became known as 'shell-shock', a condition considered to have been identified by the psychologist Charles Samuel Myers (1915). The diagnostic category of 'shell-shock' brought new aetiologies to the fore which undermined hereditarian theories of psychopathology. The putative increase in

patients deemed to suffer from the trauma of war together with the observation that these patients seemed to cut across established social classes, was a phenomenon held as evidence against the conventional theory of 'inherited mental disease' (such as the Victorian notion of 'tainted families', see Myers 2015). In the aftermath of the war, the theories and practices which developed in dealing with patients suffering from shell-shock had a profound impact on changing perceptions of 'mental disorder' as a matter of 'national' and 'public health'. As Busfield notes (1998: 13), the devastating stigma of pauperisation and treatment in terms of detention did not seem an apt reward for the nation's 'public' facing up to the dangers of war, and especially ill-fitting for officers and gentlemen apparently suffering from the trauma of battle.

Changes in the public provision of mental healthcare gradually came under way with investments in new clinics and research departments in Britain. One of the earliest initiatives was the establishment of the Maudsley Hospital in 1915 by the London County Council. The Maudsley was set up to provide early psychiatric treatment with both inpatient and outpatient services. However, the outbreak of the First World War in 1914 meant that it largely functioned as a military hospital until it reopened in 1923 (Allderidge 1991).

The radical restructuring of the nineteenth-century institutions is said to have been instigated in 1930 with the Mental Treatment Act, drawing on the resolutions and recommendations of the work that had been done in the 1924-6 Royal Commission on Lunacy and Mental Disorder (2016). Histories of psychiatry often refer to the Act as the advent of a new medical era (e.g. see articles in Marks 2017); the language of the Poor Law was formally abandoned and replaced with a new language that sought to define patients not in terms of pauperisation and dangerous lunacy, but in terms of 'rate-aided persons' and 'clinical need', and, most significantly, it discarded the term 'asylum' and renamed it the 'mental hospital'. Moreover, the 1926 report by the Commission asserted 'that there is no clear line of demarcation between mental illness and physical illness', with the implication that both should be given the same medical attention and by the medical profession.[31]

These shifts have often been described as a victory and turning point in the discipline of psychiatry: psychiatrists (i.e., medical doctors) were finally given full credence as scientists of

[31] Royal Commission on Lunacy and mental Disorder (London HMSO, 1926), p. 20.

psychopathology and thus granted professional authority over the mental hospital – and over people deemed 'mentally ill'.

Psychoanalysis and the Tavistock Clinic

Another important initiative during the First World War, and one directly affected by the problem of 'shell-shocked soldiers' and the growing spectrum of 'war neuroses', was the introduction of new clinical methods promoted by the neurologist Hugh Crichton-Miller (1877–1959), who had looked to the 'new psychology' that had developed in Vienna and Zurich during the two previous decades, namely psychoanalysis (Rose 1986; Marks 2018).[32] This led to the establishment of the Tavistock Clinic in 1920 under the organisation name of the Tavistock Institute of Medical Psychology, a private institute specialising in both psychotherapeutic training and treatment.[33] The early vision of the Tavistock Clinic, as pioneered by Crichton-Miller, was to de-medicalise the conventional treatment of patients which meant that there were no doctors in white coats, no detention units, and no medical restraint equipment – three defining features of the asylum. The Tavistock was also one of the first 'outpatient' clinics in Britain, providing services on the basis of voluntary admission. Although it was originally a private clinic (like most other psychotherapy clinics that followed after), the Tavistock Clinic became part of public mental health services with the implementation of the National Health Service in 1948.

During the 1920s, the Tavistock was the first clinic in Britain to apply psychoanalytic and psychodynamic approaches to mental disorders in an institutional setting (Turner et al. 2015). However, whilst the first three decades of the twentieth century can be seen as the early heydays of psychoanalytic thought amongst intellectual elites in Britain (Rose 1986), psychoanalysis still remained 'strongly opposed by the general public, the Church, the medical and psychiatric establishment, and the press' (Kohon 1986: 28). Such opposition was also evident from psychoanalysis' limited institutional endorsement: the Tavistock Clinic sought to obtain official recognition as a postgraduate training institution by the University of London on several

[32] Several influential articles and books on psychoanalysis were published in the first two decades of the twentieth century and many were translated into English. Sigmund Freud's first book, *The Interpretation of Dreams,* was published in English in 1915 [originally published as *Die Traumdeutung* in 1899].

[33] It was originally to be termed simply the 'Tavistock Clinic' but due to its location on Tavistock Square and complaints from the General Post Office it was formally named 'The Tavistock Square Clinic for Functional Nervous Disorders.' It was known as simply 'the Tavi'.

occasions, but its proposals were constantly rejected (Dicks 1970). And whilst the seeming pervasiveness of shell-shock, and the psychoanalytic theories which accompanied it, had a significant impact on the work and research of some doctors and academics, [34] psychotherapeutics in general remained a marginal activity in Britain up until after the Second World War (Jones 2004).

In addition to this, it seems important to note that despite the Tavistock Clinic's philosophical anchoring in psychoanalysis, as a form of treatment however, psychoanalysis was only provided to patients by a few trained specialists at the Clinic. The Tavistock is said to have been unusually diverse in terms of both treatment and training beyond psychoanalysis, bringing together social workers, psychologists, psychiatrists, neurologists and psychotherapists in the courses and services it offered (Tavistock and Portman 2009). It became known for new 'psychological' and 'social' understandings of psychopathology and intervention, and for taking issue with a singularly physiological and hereditarian notion of mental disorder and its 'carceral' intervention model (Rose 1986). The Tavistock also became part of the 'mental hygiene' movement, which introduced methods for prevention and early intervention that attended to 'bio-psycho-social' processes and emphasised 'the individual case' by situating people in their 'social environment' in which symptoms were seen to occur (Dicks 1970).

Such ideas and practices, radical as they were felt at the time, continued to challenge institutional arrangements that underpinned 'public sector' provision with its custodial asylums. Nonetheless, change in the legal and institutional constitution regarding 'mental treatment' only came about after the 1930 Mental Treatment Act, when British psychiatry eventually vindicated many of Crichton-Miller's contentions. In the aftermath of the Second World War, one contention that became increasingly salient was the proposal of attending to the *economic* benefits of 'good mental health' – such an aspiration was linked to other 'science and society' issues following the war – which went beyond the idea of the 'individual patient' or 'subject' (the conventional objective of psychoanalysis) and rather conceived of health in terms of the nation's population as a whole construed as 'the public'. The present-day conception of 'public mental health' is in many ways owed to this ambition.

[34] For example, the anthropologist W. H. Rivers and his colleagues (see Sullivan 2012).

The lab and the clinic: The Institute of Psychiatry and the Maudsley Hospital

The use of some form of psychotherapeutics in what became known as the 'public sector' of mental healthcare can therefore be seen to have been practised in some form since the opening of the NHS in 1948 when the Tavistock Clinic became part of the new public health service together with the Portman Clinic, another psychoanalytic institute.

However, the introduction of psychotherapeutics into the NHS which in many ways could be said to have laid the foundation of Cognitive Behavioural Therapy (CBT) was not a result of the Tavistock or Portman implementation. Rather, at the end of the Second World War and in the post-war years that followed, the newly founded Institute of Psychiatry at the Maudsley Hospital combined laboratory and clinical research in the development and application of behavioural approaches to mental illness. As Marks has noted (2012: 1-2), histories of CBT frequently cite American psychiatrist Aaron Beck and the psychologist Albert Ellis as the original inventors of 'cognitive therapy' in the 1950s and 60s (cf. Beck and Rose 1979), and tend to pay little attention to the development of behavioural approaches in Britain which predates the work of both Beck and Ellis. We turn now to some of the historical specificities that gave rise to a form of psychotherapeutics that became known as 'behavioural therapy'.

When the Second World War broke out, most of the staff from the Maudsley Hospital were moved to the Mill Hill emergency premises outside London to treat soldiers and military personnel suffering war neuroses. In 1942, the clinical director of the Maudsley, Aubrey Lewis, appointed the German psychologist Hans Eysenck to do psychological research at the Mill Hill (Derksen 2000, 2001). Eysenck shared Lewis' vision of establishing psychology as an experimental laboratory science on which psychiatry could rest as the 'intervention science'. At the Maudsley, psychology was thus practised as 'a basic science of psychiatry' in the study and treatment of psychopathology – this pursuit was an explicit attempt to align psychology and psychiatry with medicine where physiology had long been established as the 'basic science of physical disease' (Lewis 1967: 7). Aubrey Lewis' vision for the Maudsley was partly inspired by the influential work of Emil Kraepelin, whose definition of 'clinical psychology' referred to the 'psychological laboratory' in his psychiatric clinic in Munich, in which psychologists-as-scientists applied the theories and methods of experimental psychology to construct psychiatric treatments (Kraepelin 1896). In post-war Britain, clinical psychology as a discipline and profession was thus originally established as a science in the clinic at the service of psychiatry.

At the end of the Second World War, Lewis and Eysenck returned to the Maudsley Hospital and the Institute of Psychiatry was founded when the Maudsley was amalgamated with the Bethlem Royal Hospital, which provided the financial means of the Institute. In 1947, Lewis appointed Eysenck to head the new Department of Psychology at the Institute of Psychiatry, setting up the first postgraduate training programme to establish the professional position of the 'clinical psychologist' (Derksen 2000: 4).

After the war, the integration of the Institute of Psychiatry and the Maudsley Hospital as part of the NHS introduced the provision of psychotherapeutics in the form of behavioural therapy, distinct from the psychodynamic tradition of the Tavistock, which had also become part of the new public health service. However, the original implementation plans of the NHS did not include mental health services (Busfield 1998: 16). It was only with the inclusion of state-funded mental hospitals in the NHS plans of 1944, under the insistence of the Minister of Health Aneurin Bevan (Foot 1975), that psychotherapeutics consequently came to occupy a position in the provision of psychiatric treatment. Whilst psychotherapeutics in the public sector remained considerably limited in post-war Britain, it had nonetheless become an object of renewed scientific interest pioneered by the Institute of Psychiatry and the Maudsley Hospital as a unified teaching, research and healthcare institution.

The invention of IAPT

In 2007, on World Mental Health Day, a new healthcare programme by the name of 'Improving Access to Psychological Therapies' (IAPT) was officially announced in the UK by clinical psychologist David Clark and economist Richard Layard.

This initiative, which had won the support of the Labour Government in 2005, called for the implementation of specifically 'evidence-based psychological therapies' in the NHS (Pickersgill 2019). The subsequent implementation of the IAPT initiative in the NHS as the first psychological healthcare service of its kind was widely acclaimed as a 'scientific' achievement for psychological therapies and clinical psychology (Department of Health 2010; Hall et al. 2015; Layard & Clark 2014). Yet since IAPT's inception, the service and its proclaimed achievements following its nationwide implementation have been met with intense criticism from practitioners of psychotherapy (see e.g. Leader 2008; Lees 2016; Rizq 2012; Samuels & Veale 2009).

This opposition, and the diverse range of critical voices contained by it, has been asserted primarily by practitioners of psychotherapeutic schools and disciplines generally excluded from the 'evidence-based' classification as authorised by the National Institute for Health and Care Excellence (NICE).[35] But points of contention have also been voiced from within the 'evidence-based'-labelled community, by CBT practitioners and clinical psychologists alike. IAPT therapists drawing on their own work experience have increasingly taken issue with various aspects of the service (see e.g. Binnie 2015; Steel et al. 2015). Despite IAPT's continued self-celebration (Clark 2018; Layard & Clark 2014) and reported success in the UK (e.g. Department of Health 2010; NHS Digital 2018), concerns and criticism from both within and outside the service seem to pervade (see e.g. Pilgrim 2009; Rizq 2012; Williams 2015; Binnie 2015; Lees 2016). We explore these critiques in Chapter 3.

IAPT's acclaimed success has also been reported on internationally, featuring for instance in renowned academic journals such as *The Lancet* and *Nature*; the latter journal described the IAPT service as representing 'a world-beating standard thanks to the scale of its implementation and the validation of its treatments' (*Nature* 2012: 473). In a *New York Times* article titled 'England's mental health experiment: no-cost talk therapy' (Carey 2017; as cited in Pickersgill 2019: 628), IAPT was acknowledged for its 'ambitious effort to treat depression, anxiety and other common mental illnesses'. In a conference in 2018 that celebrated the 10th anniversary of IAPT, I watched the founder David Clark give a presentation (in his capacity as the 'National Clinical and Informatics Advisor for IAPT') in which he told the audience that several other countries are 'developing plans for IAPT-like CBT services'. 'Building on the UK model, Norway now has 40 IAPT services', he said exultantly, 'and Australia's *NewAccess* for depression and anxiety programme is also strongly influenced by IAPT'.[36] All such public commentary has elided IAPT with CBT and vice versa, and in turn hailed both as the gold standard of psychological healthcare.

It was partly through the movement of EBM that psychological therapies secured a scientific status on an equal footing with biomedical therapies, the latter consisting mainly of

[35] These include various subsets of psychoanalysis and psychodynamic psychotherapy, including 'creative' or 'expressive' psychotherapies (e.g. art therapy, play therapy, music therapy).

[36] This reported success of IAPT has also prompted calls recently for the adoption of similar national psychological health services in Holland, Belgium, Sweden and Denmark. However, such calls have not been without contention; for instance, psychologists and psychotherapists in Sweden have issued official statements objecting to the Swedish Government's implementation plans (see, for example, debates in Ankarberg 2017).

psychopharmaceuticals. The 'evidence' to which the academic and popular CBT literatures refer has been produced according to methodologies drawn from EBM (see Parry 2000; Salkovskis 2002; David et al. 2018). Within this framework, evidence is ranked according to the reliability and verifiability of the epidemiological research design used (Lambert 2006). The randomised control trial has become the gold standard, followed by meta-analyses and systematic reviews (Timmermans & Berg 2003; Pearce et al. 2015). In Chapter 5, we return in more detail to the epistemic underpinnings and implications of this scientific epistemology.

As noted in Chapter 1, evidence-based practice can be said to have become formally institutionalised in England and Wales with the foundation of the National Institute for Health and Care Excellence (NICE). This Institute was originally termed the National Institute for Clinical Excellence (hence the abbreviation: 'NICE') when Tony Blair's Labour Government was formed in 1997. It was then officially launched in 1999 in an attempt to end the so-called 'postcode lottery' of public healthcare in NHS England and Wales (Dobson 1999). In 2005, it joined with the UK Health Development Agency and was renamed as the National Institute for Health and Clinical Excellence; following the Health and Social Care Act 2012, it changed again to its current name (adding 'care' to reflect new regulatory responsibilities for social care) whilst also attaining the status as an Executive Non-Departmental Public Body (ENDPB). ENDPBs are organisations that deliver and regulate particular public services; although they are not officially part of a governmental department, they are still 'sponsored' by departments – NICE is under the Department of Health – and ministers are ultimately responsible to Parliament for their department's sponsorships. NICE is overseen by its own self-appointed board (Cabinet Office 2007).

NICE was designed to evaluate the cost-benefits of particular treatments within the framework of a state-funded healthcare system and to provide guidelines for NHS practitioners for best clinical practice (NICE 2019). Published in 2004, the NICE guidelines on anxiety and depression stated that, 'When considering individual psychological treatments for moderate, severe and treatment-resistant [i.e., resistance to antidepressants] depression, the treatment choice is CBT'.[37] The 2004 NICE guidelines were a significant achievement for CBT as it laid a

[37] Published in December 2004, see article CG23: https://www.nice.org.uk/guidance/CG23. This version has since been updated and replaced by CG90: 'Depression in adults: recognition and management' (published October 2009, updated April 2018): https://www.nice.org.uk/guidance/cg90.

political foundation on which IAPT could be designed and lobbied successfully by Clark and Layard.

Disciplines join forces: clinical psychology meets 'happiness economics'

The IAPT programme was thus said to have been designed by clinical psychologist David Clark and economist Richard Layard in the early 2000s before it was formally launched in 2008. As I suggested in the previous chapter, Clark and Layard were instrumental in framing a putative crisis in British mental health as a problem of 'access' to care, and to then delineate the solution to this problem in simultaneously clinical and economic terms. In lobbying the Government, it was argued that public mental healthcare should be optimised by improving access to evidence-based psychological therapy whilst such improved access would also have immense economic benefit for the UK (for example by reducing unemployment benefits, cf. The Centre for Economic Performance 2006; Layard et al. 2007). Underscoring this argument was a claim derived from 'happiness economics' (cf. Layard 2005b) that the improvement of psychological wellbeing, on the one hand, and economic welfare, on the other, are not separate aims or domains of inquiry but rather form part of the same goal, with the former enabling the latter.

It was at a British Academy event held in 2003 that David Clark is said to have first met with Richard Layard, after which they started working together to incorporate psychological therapy in UK policymaking (Evans 2013; Layard and Clark 2014). In the context of British mental health, Richard Layard was already known for his research on the economics of happiness and wellbeing and his formulation of 'happiness economics' epitomised by the book *Happiness: Lessons from a New Science* (Layard 2005a). Happiness economics can be summarised briefly as concerned with the study of how improvement in what is termed 'happiness-related measures', such as 'mental health', can increase 'economic life' (ibid.). Layard's interest in mental health as the prime indicator of 'national happiness' subsequently resulted in his focus on psychological therapy as a clinical-cum-economic solution to a reported mental health crisis in the UK (Layard 2005b; Helliwell et al. 2012). According to Layard, the 'subjective happiness of a population' was linked to the economic growth of a nation. 'Mental health' was thus reified as both obstacle and solution to Britain's economy (Layard 2005a).

As we saw in Chapter 1, the category of 'depression' proved tremendously important in situating clinical psychology in the rationale of happiness economics; in different ways, Clark

and Layard's professional work had revolved around the problem of 'depression'.[38] Clark for instance had long been engaged in research into cognitive behavioural interventions for people diagnosed with depression. After meeting Clark, Layard appears to have begun a more systematic dissemination of documents and presentations on 'depression' embedded in a discourse of the constitutive effects of 'mental health' on 'the economy' (e.g. Layard 2005a, 2005b; see also Pickersgill 2019a). Layard's publications seem to have caught the attention of senior Labour figures and other important political figures and institutions (ibid.). For example, the Prime Minister's Strategy Unit invited Layard in 2005 to a seminar at which Clark was also present (Evans 2013b) to present a report titled 'Mental health: Britain's biggest social problem? (Layard 2005a). This report asserted that 'There are now more mentally ill people drawing incapacity benefits than there are unemployed people on Jobseeker's Allowance' (Layard 2005a 1). Mental illness, Layard claimed, 'imposes heavy costs on the economy' (ibid.). Perhaps unsurprisingly, Layard proposed that the solution to these economic issues was to be found in an extensive investment and expansion of psychological therapy and trained mental health professionals. These publications laid the foundation of another influential report published a year later by the Centre for Economic Performance (2006): *The Depression Report*, also discussed internally as 'The Layard Report'. [39]

Following a period of intensive lobbying by Layard and Clark, the proposal of an evidence-based psychological therapy service as part of the NHS was successfully incorporated into the New Labour's manifesto for the 2005 election. The Manifesto designated 'behavioural' therapy as the preferred means of psychological treatment alongside biomedical 'drug therapies' (The Labour Party 2005: 65). Following Labour's election victory, Clark was largely responsible for designing the service resulting in the first implementation framework of 2006 (Clark et al. 2009). Clark and his colleagues initially designed IAPT to provide CBT exclusively to treat 'mild

[38] David Clark is currently Professor of Psychology at the University of Oxford, where he also first studied experimental psychology before training as a clinical psychologist at the Institute of Psychiatry and Maudsley Hospital. In 2000, he became the Head of Psychology at the Institute of Psychiatry where he set up 'The Centre for Anxiety Disorders and Trauma' together with fellow Oxford psychologist Paul Salkovskis and Clark's wife, Anke Ehlers, a professor in experimental psychopathology at Oxford. Since the launch of the IAPT service, Clark has continued to act as National Clinical Adviser to the Department of Health when new policies and regulations concerning the service are introduced.

Richard Layard is a well-known labour economist and was formerly a professor at the London School of Economics and Political Science (LSE). Layard had been appointed to the UK House of Lords in 2000 after having become a prominent figure in New Labour party politics. Layard also remains a member of the Labour Party and the House of Lords.

[39] *The Depression Report* was released on 19 June 2006.

to moderate depression' and 'anxiety disorders' in accordance with the NICE guidelines of 2004. However, cognitive behavioural therapies have since proliferated (Marks 2012, 2017), incorporating also mindfulness in the form of MBCT (Cook 2016, Drage 2018) under the banner of evidence-based psychological therapy.

We could summarise Clark and Layard's promotion of the IAPT programme as proposing two overarching and interlinked objectives: 1) to implement and improve access to evidence-based psychological therapies, in order to; 2) meet the rapidly growing demand for mental healthcare in the UK. These objectives did not, of course, emerge unrelated to circumstances that were already taking shape in and around the NHS. Issues relating to questions of access, evidence, and accountability had been a concern across several public sectors since at least the 1990s (Shore & Wright 1999; Strathern 2000) and were also of central concern in the movement of EBM of the same period (Lambert et al. 2006; Timmermans & Berg 2003). EBM's influence on psychology is said to have been partly a reaction to an increasing conception amongst clinicians and public health policymakers that 'the public' was not provided with the 'best practice' in mental healthcare due to empirically unsupported treatments (Department of Health 2010; Turner et al. 2015; Clark 2018). From the first implementations of IAPT, CBT was singled out as the foremost psychological intervention with an established evidence base (Clark et al. 2009; The Centre for Economic Performance 2006). The past twenty years have seen a rapid increase in scientific research investment in a range of CBT-based interventions, many of which have now received broad scientific recognition.[40] The reported efficacy of CBT has been widely documented with reference to mild and moderate depression, anxiety, PTSD, OCD, and various eating disorders.[41]

It also seems important to note that the notion of, and attention to, 'the mental health of a population' was linked to an older conviction constitutive of the NHS itself, namely the idea that 'the physical and mental health of a nation' is generative of a 'healthy' national economy

[40] For systematic reviews, see e.g. Butler et al. (2006); Hofmann et al. (2012); Öst (2008). The terms 'empirically supported therapy' (EST) and 'evidence-based therapy' (EBT) have become largely synonymous with CBT within the NHS (including CBT-derived therapies such as 'mindfulness' [i.e. Mindfulness-Based Cognitive Therapy]; see 'NHS CBT': http://www.nhs.uk/conditions/Cognitive-behavioural-therapy/Pages/Introduction.aspx [accessed April 2018]; and 'The Evidence Base for Psychological Therapies: Implications for Policy and Practice': http://www.nhs.uk/conditions/Cognitive-behavioural-therapy/Pages/Introduction.aspx [accessed April 2018].

[41] See, e.g., Clark et al. (2003); Freeston et al. (1997); Salkovskis et al. (2003); Tang et al. (2005); Teasdale et al. (2002).

(Busfield 1998). In a slight inversion of this rationale, however, Layard argued that there was a significant disparity between increased national economic growth and a decline in the 'mental wellbeing' of the UK population (Layard 2005b, 2006; see also Layard and Clark 2014). As noted above, Layard proposed that the explanation of this disparity was to be found in 'happiness economics' which seeks to measure 'happiness-related' issues such as 'mental health' – proposing, for example, a 'Gross National Happiness' index – rather than 'economic productivity' (e.g. Gross National Product [GNP]) as an indicator of the progress of 'the economy' (ibid.). The IAPT service with evidence-based psychological therapy at its heart was thus presented, as we saw in Chapter 1, as the key solution to problems framed as 'social' and 'economic' that were identified as a consequence of mental ill-health, especially 'depression' (Clark & Layard 2005, 2014).

We could say that IAPT emerged as a joint 'psychological-economic' enterprise. Not only was evidence-based psychotherapy deemed effective in scientific and clinical terms, it seemed also to be a tremendously 'cost-effective' approach in economic terms: IAPT, it was argued (Layard et al. 2007), would eventually pay for itself by increasing productivity (employment) and thus reduce state benefits.

In summary, 'talk therapy' and 'drug therapy' in the UK can now be seen to have become equals – sometimes rivals, sometimes companions – as therapeutic solutions to 'common mental health problems' like depression and anxiety. With the reported demand for new effective treatments and a continued increase in the use of anti-depressants in the UK, the introduction of the IAPT programme as a 'free' psychological health service was therefore deemed by its founders and by other advocates in clinical psychology and economics (e.g. Hall et al. 2015; Helliwell et al. 2012) to be greatly 'needed'. In the meantime, other mental health professionals have mourned the end of what they see as a more 'relational' practice of psychotherapy (Lees 2016).

'IAPT', as one critic put it, offers 'second class therapy for citizens deemed to be second class' (Samuels 2016: xii). We now turn to some of these tensions following the institutionalisation of IAPT and the perceived success of CBT.

chapter three

Arbitrary measures

Critical significance

'The more I do evidence-based psychotherapy, the less I believe in it', Rosie remarked gloomily as we were heading out for lunch after a staff meeting at the university department where she taught psychology. It was important to therapists like Rosie that psychotherapy still means that someone is taking care of you: 'there is a *relationship* in psychotherapy and that's what matters.'

This chapter points to some tensions between how social anthropologists have tended to situate and theorise psychological worlds and how professional practitioners in such worlds have done their own situating and self-commentary. Such a juxtaposition is not intended to align or conflate the two (the anthropologist and the people studied) but to draw attention to how mental health professionals themselves produce critiques familiar to social anthropology and, importantly, how such critical assessments often imply similar contentions that have tended to preoccupy anthropological theorisation of the 'psy' disciplines and its practitioners (cf. Rose 1989, 1996).

It is, therefore, the critical significance of psychological therapy that is the topic of this chapter. By 'critical significance' I mean to indicate how critiques of IAPT have been framed by mental health professionals themselves and the significance of such critiques. In the following paragraphs, we will see how certain critiques of IAPT that I encountered during fieldwork with IAPT professionals wielded techniques of contextualisation and critique that have also tended to inform the analytical languages of social scientists in their discussions of psychological therapy. We might reflect that an outsider's analysis may not always differ significantly, therefore, from what is already contained ethnographically in the critical discourses mobilised here by the psy practitioners themselves. This is not a failure of analysis but an ethnographic note on the widespread persuasiveness of a particular kind of critique.

We will see first some common critiques of IAPT from within the service itself (that is, by the therapists working in the service), after which we turn to social anthropology. First, I describe some key features of the IAPT service in more detail. 'Screening' and 'recovery' are deemed to be measures fundamental to the monitoring of psychological therapy but they are also burdensome for many therapists, as we will see, who now feel that the service they work in has become a 'factory of therapy'. In the meantime, I suggest that the metaphor of the 'factory' has contributed to certain visions of accountability that have made IAPT conceivable; some practitioners feel, however, that it is precisely this pursuit of accountability which makes IAPT

fail in practice: the complexity of care – 'the relationship in psychotherapy' – is deemed to be at stake.

We explore these concerns as we turn to some contextualisations of IAPT and the question of 'responsibility'. Anthropologists' increasing attention to the notion of responsibility owes much to scholarly debates in the social sciences about the significance of (neo)liberal processes of subjectification and (self-)governance in the proliferation of psychological therapies. Social scientists, including anthropologists, might classify themselves as being radically different from the psy practitioners studied here, but they nevertheless share with them many of the same compelling critical stances.

The stepped-care model

The IAPT service is provided as part of primary care in NHS England and operate on a 'stepped-care' model. This stepped-care provision of psychological healthcare was built in part on principles derived from the economic model of 'managed care' that began to inform the NHS in the 1980s.[42] The NHS was to rest on three m's: managers, markets and measurement (Ferlie et al. 1996).

As we saw in Chapter 1, the stepped-care model of IAPT is based on a 'triage' approach to healthcare in which the classification of degrees of clinical urgency decide the assignment and course of treatment.[43] The IAPT service's three 'steps' is also a division of labour and a hierarchy of intervention. Intervention is understood in terms of 'intensity', from 'low-intensity therapy' ('step 1' and 'step 2') to 'high-intensity therapy' ('step 3'). These 'steps' correspond to a specific therapeutic profession in the provision of treatment: low-intensity therapy is administered by Psychological Wellbeing Practitioners (PWPs) and step 3 is provided by CBT therapists.

Screening

People usually enter the IAPT service by referral through their General Practitioner (GP), as well as through self-referral via NHS websites or over the telephone. We saw in Chapter 1 that

[42] Managed care developed primarily in the US and came to the fore with the enactment of the U.S. Health Maintenance Organisation Act of 1973. A form of managed care was introduced in the UK ten years later in 1983 when Margaret Thatcher's Conservative government commissioned the businessman Roy Griffiths to write a report on the 'general management' of the NHS (Griffiths 1983).

[43] For an illustration of the stepped-care system, see Figure 1 in the Appendix.

self-referral is a defining novelty and key component of the 'improving access' scheme. During my fieldwork, it was frequently explained to me how self-referral was aimed at people considered to be disinclined to consult their GP because of 'social stigma' or 'embarrassment' still associated with 'seeing a psychotherapist'. However, some of these same professionals likewise saw the practice of self-referral as having overburdened the already unmanageable waiting lists.[44]

Following referral, a person is placed on one of three 'steps', based on a diagnostic assessment usually conducted over the telephone. These are called 'screening calls'. PWPs conduct the initial screening call using diagnostic patient questionnaires or 'measures'. This usually takes between 10 to 15 minutes. The severity of symptoms assessed through the initial screening call determines the degree of 'intensity' of treatment.[45] The 'low-intensity' treatment offered to those placed in the category of step 1 or step 2 consists primarily of 'guided self-help', 'psycho-education' and/or 'computerised CBT (cCBT)', all provided by Psychological Wellbeing Practitioners. Those placed in step 3 qualify for a 'high-intensity' treatment involving a specified number of CBT therapy sessions (usually between 6 – 12 sessions, depending on the diagnosis). 'High intensity' is thus the only category through which there is a guaranteed course of psychotherapeutic consultations with a CBT therapist (or other accredited IAPT psychotherapist).

Screening is often said to be provisional; a diagnosis may change following the commencement of treatment, for example, after a first consultation with a CBT therapist, although I was told that 'provisional' assessments rarely change in practice. Both the practice of screening and subsequent 'assessments' entail a checklist of 'exclusion' and 'inclusion' criteria informed by the publications of international diagnostic manuals of psychopathology.[46]

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[44] The criticism has been firmly countered by the founders of IAPT in their book *Thrive: The Power of Evidence-based Psychological Therapies* (Layard and Clark 2014). Clark and Layard argue that people who receive treatment through IAPT's self-referral tend to have a markedly quicker recovery than people who get referred by a GP or social worker. One of the reasons, they argue, has to do with the fact that people who self-refer often are more 'independent' about their mental health compared to 'the average person' who gets referred through 'the system'.

[45] This involves classifying a 'patient' and classifying a condition in accordance with three definitions of the degree of psychological acuteness: 'mild', 'moderate' or 'severe'.

[46] These are DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders 5th ed.) published by the American Psychiatric Association (2013) and the ICD-10 (The International Statistical Classification of Diseases and Related Health Problems 10th ed.) published by the World Health Organization (2017), the latter of which is the official manual in the UK (although the ICD manual is strongly influenced by the DSM).

Recovery

The daily actions that IAPT professionals are required to take 'to manage the waiting list' are often accompanied by a worrisome awareness of the shortage of 'proper treatment' available to those who are taken off the list. An important aspect of this concern has to do with the statistical measure of 'recovery rates'. 'Recovery' means that someone who has been a 'patient' emerges – as a 'recovered patient' – with insignificant or no symptoms at the end of their treatment. 'Symptoms' are determined by scores recorded on scaled questionnaires (or 'measures') which have been designed to assess a specific, predefined condition. Questionnaires are usually handed to patients at the end of the therapy session to fill out.

The national target goal for the total population of 'recovered patients' is set by the Government. The Government target is that 50% of eligible referrals to IAPT services should move to recovery (Department of Health 2015). 'Eligible referrals' are patients who have completed a course of treatment in the year of having started treatment following assessment; these patients thus make up a separate statistical group of the overall referrals to IAPT since not all referred patients start or finish their assigned treatment plan. Annual targets for recovery rates for local IAPT service providers are stipulated and regulated by the Clinical Commissioning Groups (CCGs). The NHS in England is split into CCGs. These are clinically-led organisations that are responsible for the planning and commissioning of healthcare services in their regional areas. CCGs are accountable to the Secretary of State for Health through NHS England and are measured according to how much they improve treatment outcomes for the entire regional population which they administer. All IAPT service providers — in clinics, hospitals, community centres, and so on. — are accountable to their CCG. IAPT services are thus required to meet the annual targets for recovery rates instituted by their CCG who commission the specific services. This means that if an IAPT service provider fails to meet the specified percentages of patient recovery, they risk getting their funding cut. In some cases, the CCG might decide to close the service altogether and prioritise funding of other NHS services.

Recovery is measured in terms of 'caseness', which means that a patient has been assessed to have enough symptoms of a mental health problem and thus be classified as a 'clinical case'. That is, the patient must score below the 'clinical'/'non-clinical' threshold on the relevant measures at the end of treatment to be placed in the category of 'recovery' or 'moving to recovery' (cf. NHS 2018). The concept of threshold (or 'limen') derives from nineteenth-

century physiology where it was used to denote a boundary between perceivable versus non-perceivable stimuli or responses (Young 2017). Subsequently, such ideas informed psychologists in the early twentieth century concerned with psychological assessment ('screening'): threshold came to refer to the liminal point or 'cut-off' in diagnostic questionnaires that score a patient's self-reported 'physical' and 'mental' experience.[47] Psychological questionnaires, as Young (2017) has put it, became technologies for 'numbering the mind'.

The concept of recovery, as it has been taken up in IAPT, derived in part from psychiatry where it originally referred to the end of a particular period of illness caused by 'substance abuse' or 'drug addiction' specifically.[48] The implementation of a recovery approach in the NHS followed several official publications on the topic, such as *The Guiding Statement of Recovery* by the National Institute of Mental Health in England (NIMHE 2005), which was supported by the Department of Health. Such documents conceived of recovery in terms of how 'people experience themselves as they become empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a contributing positive sense of belonging in their communities' (NIMHE 2005: 2). Recovery was further defined as 'a return to a state of wellness' and the 'achievement of a personally acceptable quality of life' (ibid.). One of the perceived values of this 'recovery-oriented system of care' was to enable 'self-management, promote autonomy and, as a result, decrease the need for people to rely on formal service and professional supports' (NIMHE 2005: 3).

When IAPT was formally launched in 2008, it was in many ways intended to be a realisation of such sentiments, putting 'self-management' and 'autonomy' at the heart of psychotherapeutic care.

Monitoring psychotherapy

'We don't talk about people'

Screening and recovery have become installed as central technologies of measurement for monitoring psychotherapy. Monitoring the provision and outcome of psychotherapy was a key

[47] Diagnostic questionnaires in clinical psychology are based on Thurstone and Likert scales (see Young 2017).

[48] Its more recent usage in British mental health services was particularly influenced by the 'psychiatric rehabilitation' movement within the US during the late 1980s and 90s (Ramon et al. 2007).

feature of the IAPT initiative as envisaged by Richard Layard and David Clark and has remained a persuasive argument in establishing the legitimacy of the service: psychotherapy is, and should be, an accountable intervention. Accountability in IAPT has been constituted primarily through evaluations of clinical referrals, procedures and outcomes, but also through clinical guidelines, on which manualised treatment plans have been formulated. As indicated in Chapter 1, making the practice of psychotherapy amenable to a *quantifiable* evaluation framework was seen to be fundamental in accounting for the effectiveness of psychotherapy in scientific terms. We could say that a 'trust in numbers' (Porter 1996) undergirds IAPT's self-definition as an evidence-based service as much as it now informs a general pursuit of 'objectivity' in psychology (a topic we explore further in Chapter 5).

As in other contexts of accountability in the UK (see Hoeyer et al. 2019; Strathern 2000), regulatory practices in the form of standardisation, reporting and evaluation have been key to the notion of accountability in IAPT. Such practices of monitoring and audit – in particular, the laborious collection and submission of datasets (e.g. reporting on 'recovery outcomes') – have not been easy tasks to perform and therapists regularly complained to me about the 'harm' it had caused to the 'quality' of their work with patients. Surprisingly, these issues were not addressed at any of the professional IAPT conferences I attended, but they were discussed at length behind closed doors in internal office meetings, during lunch breaks and at the pub after working hours. A few (former) IAPT therapists have also reported in professional mental health journals on the problems caused by the extent to which they were required to audit their day-to-day, session-by-session therapeutic work (see e.g. Binnie 2015).

In all of this, monitoring psychotherapy was often deemed so time-consuming and all-encompassing to the extent that therapists frequently felt that they were 'neglecting' their patients. The burden of managing and meeting 'outcome targets' was felt widely throughout the services I encountered in my fieldwork. At times, these experiences were apparently so commonplace amongst therapists that some felt it had become banal – 'too obvious' – to even raise it as an issue in their own staff meetings. Therapists nevertheless still worried about the extensive monitoring of clinical practices. 'Patients', I was told on more than one occasion, 'have become numbers'.

IAPT's mass generation of data as part of accountabilities in British mental healthcare was aimed at making the 'effectiveness' of psychological therapy accountable alongside biomedical treatments provided by the NHS. As a result, psychological therapy was firmly established as

an equally valid and reliable intervention on an equal footing with psychopharmaceuticals in the treatment of mental health problems. Part of this reported success was thus perceived to have been achieved through a rigorous practice of accountability and audit. As we saw in previous chapters, it was likewise through accounting for CBT's 'effectiveness' that its promoters subsequently claimed to have demonstrated a type of psychological therapy (CBT) that was said to be far more cost-effective than anti-depressants in the treatment of depression (cf. Clark and Layard 2014). Monitoring psychotherapy therefore also made the reputed success of IAPT 'countable' in economic terms (Pickersgill 2019a). These articulations of 'successful accountability' were displayed to me through a range of statistical figures in the IAPT conferences I attended, with some of these conferences hosting David Clark as the keynote speaker to deliver the annual evaluation results of the service. It was a rare occurrence, however, to meet an IAPT therapist in these conferences who was not anxious about their collection and submission of data relating to 'outcomes' to fulfil the periodic target goal of recovery rates demanded of the local IAPT service in which they were employed.

When I did fieldwork in a CBT training course at a university in Northern England, I met Rosie, a lecturer in psychology and a practising therapist. Rosie's job was divided between training CBT therapists at the university and working as a psychotherapist herself in one of the local IAPT services. During one of our meetings, she described how she frequently worried about the direction IAPT was going in and, like others I spoke to, was happy for her words (albeit with her name changed) to go on record:

> First, there was all this excitement about improving access to mental health services. And it was exciting, I mean it's fantastic! IAPT was trying to counter the imbalance of all the resources that were being ploughed into physical healthcare and the neglect of mental healthcare in the NHS. In that sense, the initiative of IAPT is really good. […] But IAPT is becoming more exclusive… it is based on exclusion [criteria].

Rosie was concerned about the patients who end up being excluded from seeing a psychotherapist because of how diagnostic criteria are deployed. 'There are too many areas in the provision of psychological therapy where that person doesn't fit into this or that category. That's been my experience of working in IAPT so far.' I met many practitioners like Rosie who had trained as CBT therapists because they wanted to work with patients therapeutically. They

wanted to help people get well through evidence-based psychotherapy like CBT. Rosie was attracted to CBT for its 'rational' and 'efficient' approach:

> It's a form of psychotherapy that focuses on the present, it's problem-oriented and offers concrete solutions. CBT is a set of techniques – everyone can learn them. It teaches you to become your own therapist, to manage life […] But even so, like any other talking therapy, you need a good therapeutic relationship [with your patient] for CBT to work.

However, Rosie was unsure if psychotherapy would be feasible in the future with the increasing constraints put on IAPT therapists. She deplored that she often felt restricted when it came to helping patients she considered most in need of psychological care because of the demands of meeting 'outcome' targets: 'You see, the more complex cases we ascribe to our services, the lower the target and recovery rates. Seeing more complex patients means that you are less likely to keep your job.'

Back in London at the community centre, I had met IAPT professionals with similar concerns. 'The financial implications matter more to the CCGs [Clinical Commissioning Groups] than the quality of healthcare', one therapist sighed. Another complained that too many of his clinical working hours were spent on laborious administrative tasks in meeting the 'target goals' stipulated by the CCG. Others reported how they had to 'move around patients' in the stepped-care system 'to cope with the pressure'. Consequently, many therapists were particularly worried about the daily monitoring of outcomes as part of the auditing of recovery rates, including the management of waiting lists. 'It leaves me with inadequate time to care for my patients and do my work properly as a therapist', one said regretfully after one of her weekly team meetings with members of the local CCG:

> We don't talk about people in our meetings anymore. We talk about numbers and recovery rates. People – the patients – are gone from our conversations. If someone attended my team meetings, they probably wouldn't realise we were talking healthcare.

This seemed to be a common sentiment. Practitioners' experience of the loss or absence of the relationship in psychotherapy directs us to the prevalence of accountability and audit through practices of quantification whereby 'patients become numbers'. We turn now to the language of the 'factory' as experiential confirmation of this.

'A factory of therapy'

Many psychotherapists feel they are now working in services that operate like 'factories', for better or worse. The institutionalisation of new psychotherapeutics with the introduction of IAPT has prompted many practitioners to see the disciplines of clinical psychology and psychotherapy as participating in a 'needed' expansion of psychological services on a national scale. Others have criticised IAPT's seeming 'de-professionalisation' of the practice of psychotherapy as detrimental to both practitioners and patients (Rizq 2012; Lees 2016). A language of 'factory' and 'industry' has come to describe therapists' own experience of the effects of IAPT in the practice of psychological therapy and in the institutional structures in which the service operates.

The metaphor of the factory is important as it lends an understanding of IAPT as an organisation that expeditiously produces a great quantity of a specific service or product; which is exactly what therapists tended to experience and recount. Psychological care has become increasingly standardised and manualised with the institutionalisation of IAPT and related journals and conferences. Rapid growth in the demand for psychological therapies has required 'effective' provision of care. As a result, some professionals feel that the accountabilities under which IAPT now operates have compromised 'the quality' of the care provided; others argue that the service has proven both 'necessary' and 'effective'.[49] This section describes and examines some of these professional tensions.

The position of clinical psychologists in response to IAPT has clearly been ambivalent. There seems to have been overall support of IAPT, at least at its early inception, with some psychologists pointing out that their profession has worked in close collaboration with the programme at every stage of its implementation (Parry 2015). However, I met many clinical psychologists who were critical: they expressed explicit concern about the 'industrial' training format of IAPT practitioners in the context of providing the NHS with a psychotherapeutic workforce within a 'cost-effective' framework. In the meantime, other psychologists have pointed out how greater access to psychological therapies inevitably has meant the need to deliver them on an 'industrial scale', drawing an analogy to the historiography of a supposed

[49] For discussions of the disciplinary changes and perceived challenges for clinical psychology in the wake of IAPT, see Hall et al. 2015.

industrial revolution whereby 'the therapist becomes a technician within the prespecified machinery of delivery rather than a cottage industry of artisan practitioners, customising interventions for each individual' (Parry 2015: 193). Clinical psychologist Glenn Parry argues that the misgivings of many clinical psychologists about IAPT concern the new arrangements in the provision of psychological healthcare which might undermine their role as therapists by offering a less expensive alternative (Parry 2015: 191).

Some psychologists have thus seen IAPT as 'a threat' to their profession (e.g. Marzillier 2004). Others have expressed optimism. Parry himself contends that the discipline of 'clinical psychology has always succeeded in adapting to new contexts, evolving to respond to the needs of the healthcare system through innovation and reinvention' (Parry 2015: 193). He urges clinical psychology to assert its relevance as an applied science in public health in response to IAPT. However, sentiments like Parry's seemed to bypass the point that one of the two inventors of IAPT, namely David Clark, is a clinical psychologist himself; IAPT might thus be seen precisely as an undertaking to 'innovate' and 'reinvent' psychology as an 'applied science'. Clark himself seems to suggest this has been achieved through the invention of IAPT (cf. Layard & Clark 2014; Clark 2018) as it demanded psychological therapy to be taken seriously in order to respond, as Parry puts it above, 'to the needs of the healthcare system'.

However, this particular ambition to further the scientific standing of clinical psychology in public health has also taken a rather ironic form: the institutionalisation of IAPT in England has meant that clinical psychologists have been largely sidelined since the provision of psychological therapy is provided predominantly by PWPs and CBT therapists – most of whom are not clinical psychologists. The role of CBT therapists and the new therapeutic profession of PWPs seem to have been shaped by a concern to provide a 'cost-effective' workforce (Department of Health 2010). The issue at hand was summarised bluntly by an IAPT director I accompanied in a conference: 'the problem with clinical psychologists', she said, 'is that they are too expensive to employ'. Even though this often seemed to be the case in practice, this director also insisted that CBT therapists were just as competent as psychologists in providing evidence-based psychotherapy: 'There's simply no evidence that clinical psychologists do a better job at CBT than CBT practitioners themselves'.

Apart from clinical psychologists, other mental health professionals working in IAPT have similarly taken issue with the seemingly 'industrial' aspects of the service. The training of therapists and the provision of care was summed up as IAPT having become 'a factory of

therapy'. It was seen to compromise heavily on therapeutic training, providing psychotherapy of 'inadequate quality'. Other CBT therapists I met through the university training course – many of whom had first trained as PWPs – expressed their dissatisfaction with the 'insufficient, short-term training' they had initially received when qualifying for the position of PWP providing low-intensity treatment in IAPT. They felt that the clinical skills and knowledge they had obtained did not meet the therapeutic needs they were required to deal with in their daily clinical work: 'I am dealing with many patients that far exceed my therapeutic expertise in psychotherapy', said a former PWP who went on to train as a CBT therapist:

> Looking back on my work in IAPT, I find myself thinking: what on earth were we doing? I think we all thought we knew what we were doing. You see, we were working on step 2 for several years doing what we thought was CBT or a CBT-type model. But then we learned CBT [on this course] and realised "Aha!" – a lot of the stuff we were doing was wrong.

Another of his colleagues added:

> What I am doing now [as a CBT therapist] makes me question step 2. I feel sorry for them [the patients]. Because the therapy I was doing wasn't the most effective. We weren't following the protocols [of evidence-based therapy].

'It's because we kept receiving patients that weren't suitable for step 2', interrupted another. 'The thing is', she explained, 'we were getting referred step 3 patients and we were trying to treat them with step 2 interventions. All of us were working as PWPs but without step 3 training [CBT training].'

Yet in the professional conferences of IAPT, it is generally maintained by senior professionals in the field that the programme has continuously trained well-qualified mental health professionals in the form of CBT therapists assisted by PWPs. Such advocacy has been supported in several reports published by the Department of Health (e.g. 2010; 2015). According to David Clark and Richard Layard, the combined workforce of PWPs and CBT therapists has been designed to deal with the increasing demand of psychological healthcare on a national, large-scale level and, they argue, the programme has proven to be effective and meaningful in both clinical and economic terms (Layard & Clark 2014). They readily acknowledge that there is room for improvement in IAPT but have contended that it remains

a successful public health service in providing evidence-based psychological therapies – a conviction that appears to be publicly backed up by other senior spokespersons in clinical psychology.[50] Contrary to the concern of many IAPT therapists, then, many of whom see themselves involved in a 'factory of therapy', IAPT's short-term training and short-term therapy are, for these senior practitioners amongst others, both necessary and effective changes to improve access to psychological therapies.

Critiques of IAPT's perceived shortcomings – whether such have been framed as lack of training and therapeutic competence (e.g. Lees 2016), for instance, or the model of care itself (e.g. Rizq 2012; Binnie 2015) – have generally resulted in advocates justifying procedures as 'rational' and 'realistic' (or framing decisions as 'inevitable', see Pickersgill 2019a: 642) and consequently characterising critics as uninformed and irrational or out of touch with reality (cf. Fonagy and Clark 2015). These justifications and responses to critique both internally and externally appear to resort to what we might call a pessimistic realism. Resorting to a discourse of rationality, inevitability and realism has helped Clark, Layard and their colleagues to deflect critique of the IAPT programme which in turn has prompted concerned therapists to confirm that IAPT is 'not merely *a* way of developing public mental health', as Pickersgill puts it (2019: 642) but, on the contrary, '*the* only way'. In other words, although the mental health professionals I worked with at the community centre, as well as those I met through the CBT university course, were explicitly taking issue with various aspects of the IAPT service, there were others equally keen to curtail a space of further critique, reminding themselves and each other 'to be realistic'.

Related to such critiques was another common response which highlighted the difficult institutional conditions under which the service operates. These conditions were often framed as fundamentally 'economic' and difficulties that arose in the provision of care were due to therapists being required to think in 'business terms'.[51] This has generated procedures seen to undermine psychotherapeutic care. As one therapist explained:

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[50] See chapters 13, 14, 17 and 24 in Hall et al. (2015).

[51] Clinical psychology seems to have long struggled with its own self-defined 'altruistic' ethic which most practitioners feel are at the heart of psychotherapy vis-à-vis the fact that psychotherapeutic care remains an extremely high-priced form of treatment; these are uneasy contradictions pertaining to a 'big-hearted business world', as one psychologist once put it to me (Bruun 2013: 18-19).

> There's a strong business side to IAPT. The service isn't going to work unless 80% of all the people who get referred go through step 2 – if you think about it as a machine with all the different costs. But, if you look at it clinically, 80% of the people referred aren't step 2 ['low-intensity'] patients.[52] They just get shoehorned into that [diagnostic category] because services are commissioned. That's where the business aspect comes in.

Another of his colleagues then commented, in terms more accepting of what was perceived to be not a matter of business but rather a case of 'economic' constraint:

> I think the idea of IAPT is great – but in my experience, there isn't enough money to carry it out properly. I think that when the government first brought it out, they didn't realise how many people were actually going to use the service. If it worked as it was originally set out to, it would be good. However, there are now so many issues [with the service] and not enough money to deal with them. For instance, we clearly need more investment in the training of step 2 and step 3 professionals to be able to deliver effective therapy. But now we're just trying to get patients through the service as quickly as possible before waiting lists get too high.

It was in this experience of either 'business' or the 'economic' that psychotherapy within IAPT was frequently felt to have 'left behind' some of its own principles in favour of a form of care required to be cost-effective, quantifiable, and amenable to auditing. If I asked if there was another way to make psychotherapy accessible as a national health service without abandoning its principles of care, the response was that one had simply to be 'realistic': 'Psychotherapy must deal with the economic facts of society.' It has been common in Europe to think of the 'economic' as fundamental to 'society', a base on which all rests (McDonald 2012b). The economic poses as a metaphor of the 'real' and the factory has long offered a related metaphoric (Daston & Galison 2007). It was reasoned by more than one self-consciously 'realist' therapist that 'We need to acknowledge the factory-like model as a necessary condition of public healthcare'. The language of 'management' was therefore not uncommon either:

[52] 'Low-intensity' treatment is provided to 80% of everyone who is referred to the service and consists of 'guided self-help' whereas 'high-intensity' treatment offered to the other 20% consists of one-to-one consultation in the form of twelve CBT sessions with a qualified psychotherapist or clinical psychologist.

> … the heavy reliance on the DSM diagnoses are probably the only way to manage a large-scale service for a large population like the UK. Because how else would you do it? Without spending too much money, of course. Or not being able to justify the spending because psychotherapy takes time.

There were critiques that amassed realism to their side – but so could defence of the service:

> The reality is that nobody in government or the commissioning groups are going to give you money if you are telling them: "Actually, people sometimes leave psychotherapy feeling more distressed than when they arrived because they are exploring their sense of self and who they are in the world, and it is often very painful." Getting well takes time, and, even if you successfully complete twelve consultations, life doesn't stop being shitty – and you certainly don't "*recover*" from it.

In the metaphoric rendering of IAPT as 'a factory of therapy', specific political-economic understandings are put to work by the professionals themselves.[53] IAPT therapists are not alone amongst professionals of various kinds in Europe in encountering such a sense of mismatch or conflict of concerns in the context of new accountabilities (see e.g. Shore and Wright 2000; McDonald 2000; Stein 2017).

'A politically-driven monster'

'I think the problem with IAPT is all these arbitrary measures that are being put into effect', says Georgia as we sit down in her university office before one of her lectures on evidence-based therapy. She looks worried. Georgia is an energetic woman in her 40s who trained as a CBT therapist before taking up a lectureship at the same university where she did her training. Like many other psychology lecturers, Georgia's working hours are divided between academic and clinical duties; apart from lecturing and supervising students, she is also the director of a local IAPT service in the town where she lives. She still works as a practising therapist, seeing patients weekly.

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[53] Some anthropologists might want to inject a Marxist critique here, such as the theory of the alienation of labour. Although such analytical possibilities are not explored further here, it seems important to note that one of the features of the factory model is that the division of labour – e.g. people as products being divided, in the ethnography, between PWPs, computerised technologies, etc., on the assembly line of assessment and care – means that no one worker ('therapist') crafts their 'creative energy' into the working object ('the patient') and creates with them in that process (e.g. 'relational' or 'long-term therapy'). There is an interesting comparison here between marxisms and the claims of some psychotherapists who argue that the 'creative' process is in the (therapeutic) relationship.

'It's a really tough part of the country to work in', she tells me, looking up from her computer screen and turning her chair to face me. 'This NHS region has one of the most appalling mental health statistics in the UK.' I ask her what exactly she thinks is 'arbitrary' about the measures in IAPT. She often experiences a lack of therapeutic 'clarity' and 'coherence' in the referral of patients, she explains, and in the performance of assessment and treatment within the stepped-care model. Some patients are referred to as 'complex patients': 'complex', because they exhibit a range of symptoms that do not match up in any therapeutically straightforward sense, or because the patient does not seem to get any better despite various initial treatments. Georgia was also of the opinion that everyone has complex personal histories, as she put it, and that there are complex reasons for ending up depressed. 'But at the end of the day,' she told me, 'to see a therapist in the NHS, you need to fit into a category.'

It was not uncommon to hear that some people fail to 'measure up' to any of the available therapeutic 'steps' in IAPT: 'they don't fit here nor there'. The measures used were not arbitrary because the patients in question do not have mental health problems but because their problems are too 'complex' to fit the measures. The circumstances of many patients' psychological distress was not adequately accounted for, it was felt, in IAPT's assessment and treatment procedures. A characterisation of IAPT through reference to 'arbitrary measures' can seem therefore somewhat paradoxical or ironic.[54] The *arbitrariness* articulated – the experience of capricious, random, unjustified or unreflecting clinical practice – was a product of an epistemic logic of *measurement* (in the form of IAPT's self-referential system of diagnostic measures, outcome measures, performance measures, and so on), with this more generally seen to be systematic, rational, empirically supported, accountable and critical.

Due to IAPT therapists' auditing of their clinical practice, which was required of them to meet the recovery targets of their services, Georgia and others had seen how 'complex patients' – people whose mental health problems required more intensive care and skill because of contextual and clinical intricacy – had become increasingly excluded in IAPT. This exclusion of complex patients might come as a surprise to some people, it was felt, 'but it's a common strategy among clinicians in the mental health service'. It was explained to me that when IAPT therapists take on more complex cases, their service's recovery rates decrease markedly:

[54] If we consider the very practice of measuring as prevention against arbitrary decisions, then 'arbitrary' and 'measures' appear rather antithetical.

> Seeing more complex patients means lower recovery rates; and if I am not meeting my targets, why should the services keep me? I'm too expensive. [The IAPT service in] Croydon just got cut half of their staff, because they didn't meet their recovery targets.

Psychotherapy is not always a 'quick fix', Georgia asserted, even if IAPT therapies, from CBT to mindfulness, are often presented as such; another lecturer at the university whose classes I had followed had told his students how evidence-based psychotherapy was about 'getting a diagnosis; then a treatment; and then move on with your life'. Georgia was similarly critical of the language of psychology more generally. It was often a means to disguise 'politics'. Others in the service had already described IAPT to me as a 'politically-driven monster'. The 'political interest' in psychological therapy had seemingly undermined its clinical relevance. We might note that it is not uncommon in this professional world – as elsewhere in Europe – for 'politics' to be seen and cited as a domain that gets in the way of science and, by the same token, one common way of criticising the quality of both science and care is to situate them in the service of politics (McDonald 2012a; 2017). Georgia had told me how evidence-based psychological therapies like CBT and mindfulness were serving, more specifically, a 'neoliberal' agenda: 'people are somehow required to take responsibility for their own lives no matter what has happened to them…', she paused, 'but it is not always a *therapeutic* responsibility'.

The issue of 'complex patients' was presented to me as a case in point: psychological therapies do not always address other causes of people's distress or suffering. By 'other causes' were meant all other circumstances in a person's life that could not be reduced solely to a therapeutic matter: 'Not all mental health problems can be treated with mental healthcare'. As lecturer and therapist, Georgia ideally wanted a broader context: any potential patient, she stated, had to be understood in their 'social' and 'cultural' contexts. It was not clear what each of these might contain, but the more general hope was that the IAPT service would eventually take into account all such other 'external factors' as causes of the experience of ill-health. Georgia remained committed to the IAPT service in her capacity as an IAPT director and therapist, but she also insisted that she was not 'one of those' who were 'wilfully blind'. She, like others, was a realist and it was important to acknowledge that there were patients for whom medication or CBT or mindfulness just 'doesn't cut it':

> Any one of these therapies might help a little or go some way to resolve some personal issues, but you are clearly not going to "recover" if your mental distress is caused by not having enough money

to feed your children, or because you are homeless after the city council sold your flat to a housing development company.

Such 'realism' demanded critical assessment of the limitations of 'psychological therapy' for issues faced in the daily work with patients. Many of these professionals were ready to comment on 'structural inequalities' in the context of increasing focus on public mental healthcare. They feared that 'social', 'economic', or 'political' problems were often being converted into a 'therapeutic responsibility' of mental health professionals.[55] According to Georgia amongst others, increasing austerity in the UK meant that a social responsibility of the Government to ensure basic 'economic welfare' had been 'disguised' as the therapeutic responsibility of mental health professionals, such as herself, and the moral obligation of individual citizens to 'get well' no matter their circumstances. 'Of course, it's my responsibility as a therapist to help you as a patient', Georgia said resolutely, 'but the moral obligation to get well – at least well enough *to work* – is yours.' Similar critiques have recently been widely reported on (or published by practitioners themselves) in newspapers, online blogs and journals; one title, for instance, in a recent article published by the professional CBT journal in the UK, asks: 'Has IAPT become a bit like Frankenstein's monster?' (Roscoe 2019). Another article published by an IAPT therapist four years earlier asked disapprovingly: 'Do you want therapy with that?' (Binnie 2015).[56]

These therapists' critiques of issues about their professional world and how they have tended to be contextualised are evocative of recent anthropological debates on the topic of 'responsibility' in the proliferation of psychological therapies and healthcare more generally. Anthropologists working in the fields of public health and care are well-acquainted with such critical evaluations of, for instance, the economic constraints put on healthcare services; and many anthropologists reproduce similar critiques in their own analyses (see e.g. Castro & Singer 2004). There are often good empirical reasons to follow a line of critical enquiry that seeks to identify and unpack the 'political-economic' context of the maladies that people experience and convey.

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[55] Similar critiques of IAPT have also been debated by psychotherapists in a recent academic publication: see chapters in J. Lees (ed.) *The Future of Psychological Therapies*. London: Routledge, 2016.

[56] For other recent examples, see e.g. discussions in B. McInnes (2019) 'Is IAPT "too big to fail"?', *Therapy Meets Numbers* [published 18/02/2019]; P. Marzouk (2019) 'Has "IAPT" eaten itself?', *Mental Health Today* [published 07/01/2019].

We could thus feasibly argue that a tendency to *psychologise* social or economic problems is a deeply political move that locates responsibility elsewhere. Such a critique might suggest that the responsibility of governments (a responsibility that might be deemed to be intrinsically 'political', 'economic', 'social' or 'moral' – or a combination of these) is in danger of being construed solely in terms of the therapeutic responsibility of healthcare practitioners (and thus also eclipsed by it) and other caregivers (or 'the services' they represent) or the moral responsibility of 'the individual', construed as a patient or service user. The perceived psychologisation of issues deemed otherwise to be 'social' or 'political' or 'economic' – such as homelessness, urban deprivation, lack of education or carers, cuts to disability benefits, and so on – might, in an ideal world, be pointing to different solutions but we might note here that it turns on an analytical attempt to contextualise and explain ethnographic worlds by virtue of analytical referents felt to be more 'real' (in the sense of getting to the 'reality' of things). There is also a latent critique of reductionism at play here similar to that which it claims to do away with, namely a critique of 'reducing' (social, economic, political) problems to 'psychological' disorders.

Perhaps the solution is not to attest, once again, that underneath it all – the ambitions of IAPT, the objectives of psychotherapies, etc. – it was 'politics' all along. When we introduce this critique – say, if we pursue an argument along the lines of suggesting that what gets constructed as 'mental health' and 'mental illness' is *really* the result of 'political' and 'economic' interests – we are inevitably employing and reinforcing a language which is already important to many of those actively working as mental health professionals. It also tends, in anthropology, to be a 'debunking' language with which to critique psychology, but which might soon run out of steam (cf. Latour 2004).

It is not pertinent to decry or to repeat such a language of critique in this thesis, I think, although it may contain many valid concerns. Instead, I find it interesting that 'the political' and 'the economic' always tend to gain the analytical upper hand over other 'factors' in many of these debates, and that anthropological analyses of this kind often do not differ significantly from what the people studied might themselves report in their own critical voices. For many IAPT professionals, 'the political, economic, social and cultural' were all contexts already very much part of their commentary on the nature of mental health problems. This language could be, and was, mobilised as a technique of both contextualisation and critique.

A question of responsibility?

I have indicated that recent debates amongst psychologists and psychotherapists share some similar assumptions and resolutions with a social science literature that deals with what we might call *psychologisation*.[57] This term summarises a collection of related arguments which posits that certain problems – revealed to be otherwise different from what they claim to be – get construed as intrinsically *psychological* problems and hence objects of psychological knowledge and intervention; and that such a process disguises the 'real' causes of the problems at hand. In the wake of IAPT, both psychologists and social scientists were arguing – albeit with varying degrees of finesse and crudeness – that the institutionalisation of psychological therapies in the UK (indeed, psychotherapy itself) serves inherently 'political' ends (see e.g. chapters in Lees 2016).

One very common set of contemporary critiques asserts that the enthusiasm for psychological therapy in the guise of CBT and mindfulness forms part of a 'neoliberal' tactic of individual self-government in which people construed in psychological terms are rendered responsible for their own wellbeing (see e.g. Davies 2015).[58] Critical comments of this kind concerning 'neoliberalism' are largely owed to Foucault's prominent work on 'governmentality', although the specific attention to psychology draws on key arguments in the work of Nikolas Rose, Ian Hacking and other scholars in the 1980s and 90s who took Foucault's insights in different directions.

We could summarise many such critiques as situating psychological therapy in the service, not of therapeutic care, but of an 'underlying' political structure or ideology. The 'political' has often appeared in this way as the real source of the persuasiveness of what might otherwise be seen and experienced as psychological realities. We are again reminded of Rose's genealogical critique of the discourses and practices of 'psy' (1989, 1996). Anthropologists' increasing attention to 'responsibility' appears also to have emerged in the decades after Foucault's death in 1984, following the many posthumous publications of his interviews and lectures into English (e.g. Foucault 1991; see also Laidlaw 2018); anthropological suspicion of neoliberalism

[57] 'Psychologisation' is a term derived in part from the much more familiar concept of medicalisation (see Chapter 1).

[58] As Tejaswini Ganti [2014:1] has pointed out in an *Annual Review of Anthropology* article: 'Although neoliberalism is a polysemic concept with multiple referents, anthropologists have most commonly understood neoliberalism in two main ways: as a structural force that affects people's life-chances and as an ideology of governance that shapes subjectivities.'

seems, in turn, to have sparked further suspicion of everything 'psy' as a western exemplar of neoliberal subjectification. Not all anthropologists have found this kind of critical stance a useful starting point in their analyses of psychotherapy (Luhrmann 2000; Davies 2009; Calabrese 2013)[59] but, more generally, anthropologists have still tended to present their ethnographic approach to 'psy' in a way that either confirms or negates governmentality or neoliberalism more broadly (see e.g. Cook 2016; chapters in Patton 2010). This also limits the analytical affordance of the category of 'neoliberalism' itself (for a recent review in anthropology, see Ganti 2014).

Although 'neoliberalism' and 'neoliberal' remain organising concepts in much anthropological writing, they have been increasingly criticised as notions sustained by an apparently totalising form of contextualisation and critique. The concept of neoliberalism has been charged with failure to account for ethnographic particularities or to account for its articulations with other 'political-economic' formations (cf. Ong 2007; Kingfisher & Maskovsky 2008; Ganti 2014; and references therein). Some anthropologists have argued that not all individual choice stems from neoliberal politics, nor is in the service of it. Whilst some of these contemporary critiques could be said to have resurrected older issues in anthropology summarised as the structure/agency debates, we shall turn now to some of the new ethnographic directions in which these debates have been taken – towards psychological therapy.

Reflecting on the increasing political interest in evidence-based psychological therapy in the UK, Joanna Cook (2016) argues for other forms of responsibility and reflexive self-governance beyond 'neoliberal responsibilisation' (Cook 2016: 151). The focus here is not CBT, but Mindfulness-Based Cognitive Therapy (MBCT), or 'mindfulness' for short – based in part on Cognitive Behavioural Therapy – which has become part of the IAPT service. Cook echoes other anthropologists who have argued that not all forms of individual responsibility and choice (or 'freedom') are born of neoliberal politics. As Cook puts it: 'A danger of theorizing practices of subjectification as neoliberal is that they come to be read as always already in the

[59] Tanya Luhrmann, for example, condemned Foucault for having romanticised mental illness in such a way that 'did at terrible disservice to is pain' (2000: 11). According to Luhrmann's reading of Foucault's work on psychiatry (especially *Madness and Civilisation*, 1988 [originally published as *Folie et Déraison: Histoire de la folie à l'âge classique* in 1961]), he argues that earlier psy institutions like asylums were embodiments of nineteenth-century middle-class morality and a kind of 'gigantic moral imprisonment' (Foucault 1988a: 278). Luhrmann reads Foucault as suggesting that the psy discourses 'dampened the free intensity of mental illness into "the stifling anguish of responsibility"' (Luhrmann 2000: 10-11, quoting Foucault [ibid: 247]).

service of a neoliberal agenda' (ibid.). She pitches her argument against Rose's earlier historical and sociological work in particular (Rose 1989, 1996) but also against other social scientists who have followed in similar Foucauldian footsteps (e.g. Davies 2015).[60]

We can summarise Rose's critique of therapeutic knowledge regimes — the 'psy' disciplines, in his terms — as demonstrating how liberal democratic government has come into being through technologies of responsibilisation and autonomisation (Rose 1996). New forms of 'governmentality' have been constituted through these rationalities of self-governance by which we are required to act and understand our 'selves' in particular ways. Governance is psychologised, individualised and internalised. Importantly, in Rose's account, certain aspects of 'the social, political and economic' have been transformed in a therapeutic direction, as new forms of clinical expertise and a range of conditions that require 'psychological intervention' have been invented.

One could briefly illustrate Rose's argument by way of describing how the reputed 'national mental health crisis' in the UK has been construed as an object of and for psychological knowledge and expertise in the form of a national public healthcare service (IAPT) whereby other possible causes or circumstances of such a 'crisis' are disguised (hence the concept of 'psychologisation' referred to above). If we were to follow this kind of critical enquiry, one could likewise proceed to describe how 'depression' – through psychotherapeutics such as CBT and mindfulness – has become a 'mental health *problem*' linked to a perceived psychological interiority, with both the cause and solution to this problem located and explained with reference to 'cognition', 'the mind' or 'the brain'. Following Rose (1989, 1996), it is partly through such instances of subjectification that modern political governance has succeeded in rendering people into responsible, autonomous agents in the name of their own 'mental health' and 'freedom'.

For our purposes here, let me highlight two inferences from Rose's critique more explicitly. First, this strand of theorisation suggests that the disciplined capacity for self-reflexivity and self-responsibility was crucial to the formation of the human subject in modern liberal democracies from the twentieth century onwards and that the 'psy' disciplines played a key role

[60] It should be noted that Cook does not mention that this particular body of Rose's work was concerned with what he termed the transformation of political power in *liberal democracies*, showing how the psy disciplines played a significant role in shaping new forms of governance and its subjects (Rose 1985, 1989, 1996). Rose's work differs, therefore, in some important historical and analytical respects from the giant of 'neoliberalism' that anthropologists have more recently seen themselves in battle with.

in cultivating and demanding this capacity; so much so that, secondly, the very notion of the self-governing individual in pursuit of their own 'wellbeing' and 'truth' (e.g. 'my true self', 'a healthy body', 'mindful living') is a fundamental condition of contemporary political power relations in liberal or neoliberal democracies. It is this kind of analysis that some anthropologists have charged with being totalising and inadequate. Totalising because it does not seem to leave much space for subjectification practices of another kind beyond (neo)liberal subjectification; even if, indeed, such practices appear but exemplary of neoliberal self-governance – like the UK Government's recent interest in psychological therapies.

Multiplicity

In contrast to Rose and others who have presented various versions of the kind of critique sketched out above, Cook's (2016) approach claims to offer an empirical grounding for the professional concerns of mindfulness advocates and politicians through an ethnography of the political interest and 'inquiry process' into mindfulness. This inquiry took place through meetings and seminars on 'mindfulness' held in Westminster. She argues that the multiplicity of concerns and the breadth of subjectivities involved in the practice of mindfulness take us beyond the 'neoliberal critique' associated with Rose and others. Rather than insisting on the emergence and prevalence of mindfulness as another instantiation of neoliberal discourse and governance, Cook contends that therapeutic interest in self-governance does not preclude what she describes as 'social, political or economic issues'; on the contrary, she argues that 'politico-economic concerns' remain central to the professionals she studied. Cook makes the case therefore that, ethnographically, practices of subjectification are never totalising; that the specific subjectification practices of mindfulness 'may hold multiple and/or diverse meanings, and that the maintenance of this multiplicity is a motor of political process' (ibid: 141).

Cook thus mobilises the concept of 'multiplicity' by arguing that the 'breadth of subjectivities' and the notions of 'responsibility' and 'self-governance' involved in the political inquiry process in Westminster, as well as the therapeutic practice of mindfulness itself, both go beyond the influence of neoliberal subjectification. She stresses that the multiplicity of values and meanings for the people involved (the patients, practitioners and politicians) was witnessed in the political inquiry process into mindfulness therapy in Westminster, as it brought together what Cook describes in her ethnography as 'multiple levels of reality', on the one hand (e.g. 'statistics and personal testimonies' [Cook 2016: 156]), and 'multiple realities', on the other

(i.e., 'the experiences of people in diverse parts of civil society dealing with different problems' [ibid]). Through this political inquiry, Cook describes how multiple meanings of mindfulness and societal problems were orchestrated into one coherent endeavour and dialogue in which diversity was still maintained.

In this process, multiple and diverse problems and experiences were recognised, according to Cook, and '[e]vidence was presented which suggested that mindfulness-based interventions might be of benefit for a range of different problems […] without reducing them to the same problem' (ibid: 152). We might note here how an appeal to the scientific 'evidence' does the job of fitting a variety of concerns, problems, and experiences under the same banner of 'mindfulness' – and how 'multiplicity' or 'diversity' is reduced to the shifting contexts of its mobilisation. Cook herself notes how the contributions of the members of the Mindfulness Initiative 'were smoothed into a single voice' with 'no authors named in the final document' (2016: 146) when the Initiative was presented in the official report in Parliament on October 2015.

In an important sense then, the discerned 'multiple realities' of mindfulness was held in place by a noticeably singular objective: the promotion of the therapeutic effectiveness of mindfulness to a range of reported problems in British civil society. Despite the apparent multiplicity of societal contexts and professional concerns which was, according to Cook, intrinsic to the political inquiry into mindfulness, it nonetheless resulted in the production of a single authoritative report: 'Mindful Nation UK' (MAPPG 2015). We might contend, therefore, that the report was an effort to coordinate multiple voices into a single expert voice – The Mindfulness All-Party Parliamentary Group (MAPPG) – thus eclipsing the multiplicity of its own production. Importantly, the report sought to deliver an impartial evaluation of the effectiveness of mindfulness within the framework of 'evidence-based psychological therapy'. It thus presented an evidence-base for 'Mindfulness-Based Cognitive Therapy', in the singular, as a psychological intervention. As such, Cook's ethnographic case of what she terms 'multiple realities' seem nevertheless to have been coordinated into a distinct psychological epistemology with a claim on 'reality' (again in the singular): the effectiveness of mindfulness.

Cook's study shows how 'mindfulness' has indeed become a matter of concern beyond the clinical context of treating specific mental health problems. However, her ethnographic account of the political interest in psychological therapy does not make clear why a 'multiplicity of contexts' in which mindfulness has been put to work (i.e., 'health, education, workplace, and

the criminal justice system'; cf. *Mindful Nation UK* [MAPPG 2015: 8]), moves us beyond Rose's account of how (neo)liberal governance has been transformed in a therapeutic direction. One key conclusion of Rose's genealogy of the 'self' was, after all, to point out how psychological epistemologies and psychotherapeutics became constitutive of a multiplicity of contexts and problems in liberal democracies. And, importantly, how this mutual constitution in political governance and selfhood succeeded in claiming 'psychological' authority over a range of concerns – or 'multiple meanings' – beyond clinical contexts.

Certainly, as Cook's critique of Rose seems to imply, there is more to be said in our ethnographies from an analytical stance other than reporting on neoliberal subjectification. However, the *Mindful Nation UK* (2015) report and the psychological authority with which it promotes mindfulness as a therapeutic solution to a range of concerns and contexts would seem to lend empirical confirmation to Rose's earlier work and its predictions (see, especially, Rose 1996).

What about the question of 'subjectification', then, and its ethnographic specificity? We might readily concur with Cook when she argues that mindfulness as a practice (and indeed, I would add, evidence-based psychological therapy more broadly) involves multiple meanings and experiences for the people involved; that the practices of subjectification involved in evidence-based psychological therapies cannot all justly be reduced to the workings of 'neoliberalism' and that this category itself is often suggestive of a problem in anthropological analyses.[61] This assessment seems important but the seeming 'multiplicity' observed in the proliferation of mindfulness in the UK does not take us very far beyond the genealogical critique outlined by Rose and others. Practices of self-responsibility and self-management which mindfulness and CBT might seem to encourage may not always be in the service of 'governmentality' – but this kind of critique appeared monolithic and inadequate even to Foucault himself (1988, 1997; see also Laidlaw 2018).

Rather, I would suggest that it is precisely by virtue of an ethnographic attention to 'multiplicity' and 'diversity' articulated by the mindfulness advocates that The Mindfulness Initiative with its *Mindful Nation UK* report (which is, we recall, a Government-funded implementation plan) appears to be an attempt to coordinate different 'social', 'economic' and 'political' contexts and concerns into a *singularity* ('mindfulness') deemed necessary and non-

[61] Rephrasing this point, we could say that the ethnographic multiplicity is not exhausted by the anthropologist's analytical category of 'neoliberalism' or 'neoliberal'.

political. We might well want to challenge the limits of the prevalence of neoliberal framings in our approaches to psychological therapy, as Cook seems to suggest. But, within those same concerns over ethnographic sensitivity, it is pertinent to note that the Government-funded initiatives of a public health provision of mindfulness and CBT are happening in multiple contexts — schools, hospitals, workplaces, prisons, and universities — of increasing precarity in the UK. Indeed, it is this mobilisation of multiple but particular contexts and concerns – 'in diverse parts of civil society dealing with different problems' (Cook 2016: 156) – which is evocative of a governmental politics of 'life itself' (Rose 2006).

We have thus returned to an ethnographic point made earlier in this chapter in Georgia's critical assessment, as lecturer and practitioner, of IAPT's significance. Despite her obvious commitment to CBT and the IAPT service, she felt nevertheless that certain 'problems in society' had been recast as 'psychological problems':

> We are now asked to teach people CBT and mindfulness in contexts where serious political problem-solving is clearly needed. It's the job of policy-makers and politicians, not psychotherapists.

Certain aspects of the IAPT service thus failed to address, according to Georgia, 'some of the real causes of psychological distress', such as 'economic deprivation'. Like other psychotherapists I met, Georgia felt that the political interest taken in *psychological* interventions, such as CBT and mindfulness, risked obscuring *political* interventions. 'If we are going to justify a national psychotherapy service like IAPT with its introduction of CBT and mindfulness into all public sectors', she told me resolutely, 'then we need to make sure that we are treating people for all the right reasons'.

Towards a different diagnosis?

Providing effective psychotherapy is what most therapists expect to do when they train as IAPT professionals. Upon graduating from their university, many therapists find that a focus on psychotherapeutic care and patients is no longer what they can expect to do in practice. In other words, when IAPT-trained CBT therapists take up positions in the IAPT service, commencing their work as fully-fledged clinicians, their acquired understanding of what constitutes evidence-based therapy does not easily match up with the institutional requirements of putting 'evidence-based' therapy into practice. Consequently, a disturbing sense of discrepancy

emerges amongst new therapists who experience a lack of fit between their psychotherapeutic training and the kind of work which is demanded of them in the IAPT service.

Therapists are taught that 'the patients come first', even if they 'know' that this might not always be true. 'Patients' or 'people' are nevertheless what therapists are taught to care about. 'The basic goal', as the supervisor often reminded us in the training course I followed, was 'helping people get better'. It is also the reason most people enter the psychotherapeutic professions (e.g. Luhrmann 2000; Davies 2009). But not only does this therapeutic 'helping' or 'care' take many forms when put into practice, as we saw in Chapter 1, its significance and meaning shift radically into other matters of concern when we enter the institutional context of IAPT. Other circumstances are present here, other things matter: 'the national economy', 'the NHS', 'unemployment', 'waiting lists', 'transparency', 'funding cuts', 'recovery rates', and so forth. Many of these circumstances, whether seemingly abstract or concrete, were not easily reconciled with the therapists' daily efforts, in their own words, to *care* for their patients.

Monitoring psychotherapy was therefore not what most psychotherapists expected to do when they started working in the IAPT service. Aspects of accountability were deemed especially burdensome, including the daily session-by-session auditing of clinical data to accumulate 'recovery' outcomes in an attempt to meet the stipulated target goal of patient recovery. When IAPT therapists described to me why they had trained in evidence-based psychotherapy they highlighted what they saw as the 'rational' and 'relational' aspects of practising CBT, but it was the burden of accountabilities and other 'arbitrary measures' that were deemed to be obstacles to their clinical work. These practitioners felt that the therapeutic rationality of CBT and the therapeutic relationship with patients had been increasingly undermined.

Ironically perhaps, it was precisely the accountability and measurement of psychotherapy that Richard Layard and David Clark had claimed demonstrated the 'mass public benefit' of the IAPT service (Clark 2018). Such new accountabilities at the heart of the service have been summarised as extending across 'economic, epistemic, and clinical' aspects of governance (Pickersgill 2019a: 642). We could say that they have been constitutive of IAPT in a way that enabled its founders and advocates to present it as simultaneously 'scientific' and 'cost-effective' – serving both 'psychological' and 'economic' interests – which has consequently allowed them to frame any critics as uninformed and unrealistic opponents of evidence-based practice (cf. Fonagy & Clark 2015; Layard & Clark 2014).

IAPT therapists quickly get to know, therefore, that their educated trust in evidence-based psychological therapy must – in the institutional settings wherein such therapy is put into practice – shift into a 'trust in numbers' (Porter 1996). Therapists are thus required to be persuaded by new strategies of quantification and impartiality. New sensibilities must be acquired. The therapists who have not already acquired such sensibilities – who might, in their colleagues' terms, fail to get 'realistic' about their jobs – might well find themselves questioning the 'quality' and 'goal' of IAPT whereby, as more than one practitioner told me, 'patients are numbers and therapists are managers'. The accountability that imbues the provision of psychological therapies is thus not always felt to account for the reality of psychotherapeutic care with which many psychotherapists are familiar and might anticipate. Psychotherapeutic care did not seem to translate seamlessly into a professional world in which care practices are fundamentally construed as quantifiable, measurable entities that end up as numbers on a page. As we have seen, this monitoring of psychotherapy is the reason many practitioners now feel that IAPT is like a 'factory of therapy'.

Psychotherapy can seem, therefore, to collide with managerialist measurements of performance in the institutional setting of the NHS. Attempts to deal with this tension is apparent in the day-to-day working lives of practitioners, such as when therapists explicitly criticise or worry about the 'quality of care' or the therapeutic 'relationship', a disquiet which is then met with instructions from peers or superiors to be 'realistic'. When IAPT is criticised, a moral discourse of 'inevitability' (Pickersgill 2019a: 642) appears to deflect critique: 'the IAPT model is *the only way* to do it [i.e., provide public psychological healthcare]' (see also Chapter 1). Such rectifications might later be accompanied by an acquired self-conscious 'pragmatism' on the part of the same concerned therapists, reminding themselves and others to 'just do our best' in the face of an 'unmanageable' management model of psychological healthcare.

Such affirmations by IAPT professionals and the general deflection of critique by its founders and advocates have served to both obscure and prevent certain forms of critical scrutiny through which other models or approaches to public psychotherapeutic care could be appropriately envisaged and enacted. There has been some resistance more recently though, with other psychological 'futures' delineated (see Lees 2016). However, depending on how IAPT catches any critical light reflected upon it, its self-definition as a scientifically-informed programme – constructed through both 'psychological' and 'economic' justifications (see Chapters 1 and 2) – can reflect back. As a result, for professionals working within IAPT,

'occupying the available [critical] space' (McDonald 2006) would mean joining the ranks of the ill-informed, unrealistic and misguided.

This chapter has attempted to foreground common critiques of IAPT and psychological therapy. We have seen how social scientists have more recently joined the debates. However, the critiques of social scientists do not always differ significantly from the IAPT therapists I worked with, nor the critiques contained in the professional psychology literature I have cited. One obvious reason for this apparent commonality is the fact that many people featuring in this ethnography are (if not professional academics themselves) often academically educated in some branch of critical theory. Foucauldian theories of governmentality and subjectification, including critiques of these theoretical orientations, could be said to have encouraged anthropologists and psychologists alike: they have become part of the way in which anthropologists might contextualise psychological realities, as much as they have informed practitioners' own understandings (see e.g. Binnie 2015; Lees 2016; Marzouk 2019). So much so that an anthropological study of psychologists might easily run into the ethnographic wall of re-instantiating critical understandings shared amongst the psychologists themselves. This is not necessarily a problem – some anthropologists might even be tempted to call it 'ethnographic theory'[62] – but the anthropologist studying psychologists might want to bring something else to the conversation.[63] I return to this point in the final chapter of this thesis. For the moment, we might want to pause and think critically about critiques, as Latour has reminded us to do (2004). The concept of neoliberal subjectification has often been used to:

> jump straight ahead to connect vast arrays of life and history, to mobilize gigantic forces, to detect dramatic patterns emerging out of confusing interactions, to see everywhere in the cases at hand yet

[62] There has been written a great deal in recent years about what exactly ethnographic theory entails, following the launch of *HAU: Journal of Ethnographic Theory* in 2011 and its subsequent publications, as well as the proliferation of 'ontological turns' in the writings of Martin Holbraad and Morten Axel Pedersen (e.g. 2017). The point here is that whilst anthropological theorisation might well be a reconstitution, reformulation or even 'recursive' transformation of ethnographic material, the British professionals presented here, including their theories and critiques, might still feel less 'ethnographic' to some ethnographers than, say, Mongolian shamans.

[63] The relationship between analysis and ethnography, or, anthropological theory and ethnographic data, including that distinction itself (see Heywood 2018; Candea 2018c), is an interesting one but will not be further interrogated in the following, except from stressing that our own anthropological theories are of course as much available for ethnographic treatment (as Heywood [2018] has recently demonstrated) as are any other theories encountered elsewhere in the world.

> more examples of well-known types, to reveal behind the scenes some dark powers pulling the strings. (Latour 2005: 22; cited in Bell & Green 2016: 239)

The anthropological injunction to direct our analytical gaze to complexity or multiplicity has perhaps offered a way out of such 'gigantic forces', as Cook amongst others seems to suggest.[64] However, 'multiplicity' and 'complexity' have also reappeared ethnographically in this chapter: as notions that therapists mobilise to come to terms with the perceived problems and restrictions of the IAPT service. (For example, whilst the notion of the 'complex patient' was deployed as a clinical concept referring to a lack of fit between a patient and the diagnostic 'measures' of IAPT, it also became an instructive metaphor of the 'complexity' detected by practitioners in their own critical assessment of the role and significance of psychological therapy: for whom or what is IAPT good for? Why psychotherapy? Who is responsible? And so on.)

Practitioners and commentators alike have been keen to contextualise psychological therapy with reference to the 'political', whether it is framed as a matter of neoliberal (self-)governance or the displacement of 'responsibility' (e.g. political responsibility disguised as therapeutic responsibility, as Georgia suggested). In all of this, the 'political' tends to gain the analytical upper hand, as much as the therapists themselves might feel that 'politics' is what gets in the way of their therapeutic work: we see the capacity of 'politics' to dominate both ethnographically and analytically (Candea 2011, 2014; McDonald 2017).

Mindfulness and CBT, or any other type of psychological therapy, might of course be practised in multiple ways and involve diverse meanings for practitioners and patients alike. However, any such multiplicity is rarely what constitutes ideal clinical models of diagnosis and intervention – on the contrary, such models often seek universality and singularity (McDonald 2017; Mol 2002; see also Chapter 5). The IAPT model of therapy has done the work of coordination here, subsuming multiple and diverse contexts and concerns under its banner.

Recognising multiplicity in the way Cook suggests (as a form of ethnographic diversity beyond neoliberal subjectification) might seem to offer a way out of what we might call 'the ontology of the political', as Candea (2014) has incisively couched it. And yet it is interesting to note that it is once again the work of Foucault that is heralded in calls for multiplicity in the

[64] 'Multiplicity' has perhaps provided some anthropologists with a sense of analytical liberation as the (ontological) turn to 'alterity' also seems to suggest (e.g. Holbraad and Pedersen 2017).

way suggested here: the 'reflective' affordances of psychological therapy beyond governmentality, that is, as *ethical self-cultivation* and *self-care* (Cook 2015; Vogel 2017; cf. Foucault 1997, 1988c). As in other areas of social anthropology today, Foucauldian freedom seems in many ways to have succeeded Foucauldian governmentality.

chapter four

Learning to be therapeutic

Cognitive Behavioural Therapy

This chapter explores the education of therapists in evidence-based psychological therapy. We are following here the training of CBT therapists at a university in Northern England. The director of the CBT course there, a practising psychologist and lecturer, had granted me permission to follow the course and invited me to live with his family during term-time. I met his colleagues and students and I sat in on their classes, seminars, and clinical supervisions: I was committed to understanding how people become therapists.

Psychotherapeutic training can be understood as a form of 'situated learning' (Lave & Wenger 1991), although this is not as straightforward as it may sound. The approach I take here 'situates the practitioner, right from the start, in the context of active engagement with the constituents of his or her surroundings' (Ingold 2001: 5) and with all the circumstances of therapy.[65]

In this chapter, we will see how students of CBT learn to work therapeutically through a dynamic process in which they could be said to be acquiring new bodies. This dynamic process is one through which new therapeutic models and affordances can also be constituted by students as they learn to be affected by all the new circumstances that constitute 'Cognitive Behavioural Therapy'. It is a complex process that mirrors in many ways the training of other kinds of therapists, notably medical doctors (see McDonald 2014; Hallam 2017; Olejaz 2017). This process is at once a corporeal and conceptual engagement as students learn through a simultaneity of theory and practice.[66]

I suggest that psychological therapy, therefore, is not simply a case of '*talking* therapy', and that analytical overemphasis in anthropology on narrative and 'emplotment' (Mattingly 1994) is not always an instructive approach. Psychotherapists are not simply learning to 'talk' as it were (and neither are patients); learning to be therapeutic is a process that is rather more complicated: it is a process that involves articulating bodies of various kinds.

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[65] The approach I pursue here has benefitted greatly from McDonald's (2014, 2015) ethnography of how medical students learn to practice anatomy relationally; Grasseni's (2007) ethnography of cow-breeding experts in Italy and their shared aesthetic practice of 'skilled vision'; Ingold's work on the 'education of attention' (2001); and anthropological studies of scientific epistemologies (e.g. Cohn 2008, 2009; Candea 2013; Hallam 2013). It has also been stimulated by my reading of Latour (2004a) and others cited in the text and discussed in more detail below.

[66] On the notion of corporeality, see Bruun (2020).

Training and fieldwork

To become a CBT therapist in the UK, one must enrol as a student on a master's programme in Cognitive Behavioural Therapy at a British university. CBT therapists are formally educated at university level through a one-year M.Sc. degree or equivalent (i.e., HE Level 7). The CBT course consists of lectures, academic supervision, and supervised clinical practice. Students write a dissertation and must complete a 'Practice Assessment Portfolio'. This portfolio documents the 'practice units' required to meet The British Association of Behavioural and Cognitive Psychotherapy's (BABCP) training standards, which are necessary for professional accreditation.[67] Accreditation is the professional recognition of the therapist as a 'qualified practitioner' and it is required for employment in the NHS. The CBT programme consists of five 'core modules', two 'practice modules' and a 'qualificatory module' over the course of a full academic year:

1. *Fundamentals of CBT*
2. *CBT for Anxiety Disorders*
3. *CBT for Depression*
4. *Anxiety, Depression and Transdiagnostic Practice*
5. *Dissertation*
6. *Advanced Supervision of CBT Practice I*
7. *Advanced Supervision of CBT Practice II*
8. *Qualificatory Practice Unit: PgDip Advanced Practice of CBT*

The training of CBT therapists is thus structured around a combination of what is referred to as 'academic' and 'clinical' work. This pedagogical division of 'academic' and 'clinical' has been inherited by the psychotherapeutic professions from medical education through the discipline of psychiatry. The CBT course is thus part 'taught', meaning that students are trained through lectures, seminars and supervision, including the writing of termly assignments and a final dissertation; and it is part 'practice', referring to training through the practice of psychotherapy with patients, including clinical supervision and assessment of each student's own therapeutic practice. This kind of training, therefore, takes place both within the university and within clinical settings. The syllabus I was given described the course as enabling students 'to conceptualise underpinning theories and principles with practices in their own work setting'. This division of theory and practice follows common dichotomies of abstract and real, or

[67] BABCP is the professional association of CBT therapists in the UK.

'academia' and 'the real world', but the object of both here is 'human psychology': assessing and treating people with mental health problems. Workplace and clinical practice settings are external to the University and students are supervised by BABCP-accredited CBT supervisors.

So, who are the students? Three main contextual points need highlighting here. The first point to note is that the majority of CBT students tend to have considerable professional experience working in mental healthcare services. Most students have trained and worked as Psychological Wellbeing Practitioners (known as PWPs) in the IAPT service before qualifying as CBT therapists. University courses on CBT generally only admit applicants who have PWP training or equivalent occupational experience.[68] The profession of PWP is a recent occupation and it was specifically designed within the frame of the IAPT programme as a means to meet the reported demand for a 'therapeutic workforce' in NHS England (Layard and Clark 2014). Psychological Wellbeing Practitioners carry out the initial psychological assessment of patients referred to the IAPT service; the initial 'screening', as discussed in the previous chapter. They also provide CBT-based therapy to patients diagnosed with 'mild' to 'moderate' depression and anxiety. We will explore some aspects of what is entailed in learning this diagnostic classification in the pages below. It is also important to recall that the provision of psychological therapy in IAPT operates through a hierarchy and a division of labour between 'Low Intensity' (PWP) and 'High Intensity' (CBT) practitioners.

The second point to note is that some of the CBT students are trained professionals in other areas than mental healthcare; on the course I followed, I met nurses, prison officers and teachers. They often enrol on the course with some general experience of facilitating mental health support in their former employments. And finally, a small but significant number of the students I met already held Higher Education qualifications in mental healthcare such as counselling, clinical psychology, psychiatry, or in other schools of psychotherapy; these students usually pursue a master's degree in CBT because some form of CBT training has become mandatory in many psychological and medical professions.

I will speak here of the 'students' collectively but it is important to bear in mind that almost everyone who enters the course has trained and worked in the various healthcare professions indicated, and many come to train as CBT therapists on the basis of their professional work in

[68] A bachelor's degree in a relevant discipline or a qualification equivalent to Higher Education level 6 is given as standard entry requirement. Applicants must also demonstrate that they have access to patients referred to CBT, including an external BABCP-accredited supervisor.

IAPT. As a result, many students are already accepting of a not only basic, institutionalised mind/body divisions and a category of 'mental health' but are also familiar with psychological therapy. What students are learning through the CBT training can well feel like an 'extension', as some students put it, of their previous training and practice. To others, however, a certain amount of worrisome discontinuity was felt between the CBT course and their former IAPT training. The unlearning of former models of care was part of becoming what the course director called 'a real CBT therapist'.

CBT training requires its students to work therapeutically: they are said to 'learn by doing', and they participate in the actual provision of CBT therapy in a mental healthcare service. This means that students are seeing a number of 'patients' over the course of their one-year training. Although they are 'therapists-in-training', they are expected to carry out work with patients as if they were already competent CBT practitioners. This provision of CBT therapy takes the form of one-hour long 'sessions', which become the students' 'practice hours' in their clinical placements alongside their taught classes on CBT at the University.

The academic classes are taught two to three days a week and students spend the rest of their time in the clinical placement where they see patients. Whilst the students' clinical work settings are typically linked to the IAPT programme, in some cases they work in mental health services outside the NHS, such as in charities and non-governmental organisations. The academic and therapeutic work of the students is reviewed in weekly supervision with BABCP-accredited supervisors, some of whom are also university lecturers. To be awarded the master's degree, students must achieve a total of 200 CBT practice hours with patients and a minimum of 70 hours of supervision. Students must also undertake a minimum of 10 hours of personal CBT therapy with a qualified CBT therapist.

Following the training of therapists entailed sitting in on introductory and advanced classes on CBT, along with seminars and group supervisions, provided by the University. In supervisions, I watched video recordings of students carrying out therapy sessions with their patients. Like the students, I took notice of the corrections and suggestions of supervisors. I listened to the many questions and concerns that students raised during their classes and supervisions, as well as the sudden insights or resolutions that often accompanied these discussions. I was also invited to follow the lecturers to their offices before and after classes. We would make coffee and sit down at their desks and they would talk to me about teaching materials and administrative tasks, student issues and accomplishments, the state of the IAPT

service and their own clinical practice – as opposed to teaching. I would go through the curriculum frequently, noting the pedagogical literature and catching up on reading. The theoretical and clinical CBT literature is extensive, and I spent a great deal of time learning disciplines known as the cognitive and behavioural sciences.[69] When I was at the University attending classes, I would also have lunch with students in the canteen. I learned about their particular interests in CBT and in psychological therapy more generally. They would tell me about some of their concerns with the training course or their therapeutic work, but also the joys of being able 'to help people' and the sense of accomplishment when a 'treatment plan' (a set of therapy sessions) with a patient was successfully completed. I listened to some of the students' growing disquiet with the 'economic strains' and 'managerialist' practices in the IAPT service where most of them worked and would seek further employment after qualifying as CBT therapists.

Carrying out fieldwork in and around the CBT course was not self-explanatory nor was it without its problems. For example, the lecturers expected me to carry out structured questionnaire-based interviews with the students and would kindly offer to leave the classroom for an hour or two in order to let me conduct such research. I often had to explain to them that I was not really much interested in conducting interviews of that kind. Talking to students, hanging out with them, sitting in on the classes and supervisions, and so on, was more important to me: 'it's called fieldwork'. I tried to explain some of the basic tenets of this kind of research: it was empirical, but not in the same way as the research of psychologists. On my first day at the University, a senior lecturer turned to me in his office and said, 'So, I am going to leave you with the students today for a couple of hours, so you can get on with your research'. It meant that I suddenly had to jot down a list of questions five minutes before meeting the class of students that I had hoped to join as a fellow trainee. There were many occasions like these, and I soon learned to come prepared not only as a student but as a researcher in their vision of what my research participation should entail: questionnaires and interviews.

I had thought of my fieldwork as a sort of 'apprenticeship' in anthropological terms (Grasseni 2007, 2009). Despite my efforts to explain my role as an anthropologist, I was immediately identified as a visiting researcher – an expert instead of an apprentice – as in their model of scientific research. One result of this perhaps deliberate misapprehension (after all, leaving the

[69] This literature is distinguished from the also vast 'self-help' literature on CBT.

students with me allowed the lecturers to catch up on administrative work) meant that I had to pretend to 'get on' with my research in a manner they would recognise as proper scientific research. Eventually, it became an interesting lesson: the position and stance as detached observe was in itself an introduction to 'evidence-based' research of the kind that I realised these practitioners-in-training were themselves pursuing.

Taking up this position, however, I decided against the use of questionnaires and initiated instead some group discussions with the students, which allowed us to talk about their CBT training. These were discussions and conversations rather than formalised 'interviews' but were more structured, of course, than our casual chats during lunch breaks. They also moved beyond a discussion of academic work. I learned about the different clinical settings in IAPT in which students worked, some of the problems they faced on a daily basis, and much more. It turned out that such conversations also became an opportunity for the students to evaluate and reflect, in their own terms, on their progression as therapists.

While the lecturers' expectation and assumption about fieldwork defined my role as an outsider from the very beginning, I was still granted participation in the course 'as if' I was a student. There were still certain limitations to my participation as a fieldworker, and my presence had to be routinely negotiated.[70] Nonetheless, both students' and staff's definition of me as a 'researcher' first and foremost, meant that my presence in classes and supervisions was deemed to be appropriately 'ethical' (see Simpson 2011); this status as visiting researcher from a recognised university provided the necessary ethical credibility that safeguarded issues of 'confidentiality' (patients were discussed in supervisions, for example), which could otherwise have been an obstacle to fieldwork.

Learning CBT

'What is the nature of human psychology? What are mental health problems? What exactly are we dealing with?', asked the lecturer as he turned to his students in the classroom. It is a Tuesday morning and a group of fifteen students are attending one of their first introductory lectures on Cognitive Behavioural Therapy. We are learning about the 'fundamentals of CBT'. 'So, here we

[70] Negotiating fieldwork presence in clinical contexts is a common concern noted by ethnographers; for a discussion of some methodological issues, see Wind (2008).

have the classic model of CBT', said the lecturer, pointing to the diagram on his PowerPoint presentation, 'it is a general model of human psychology' (see Figure 2).

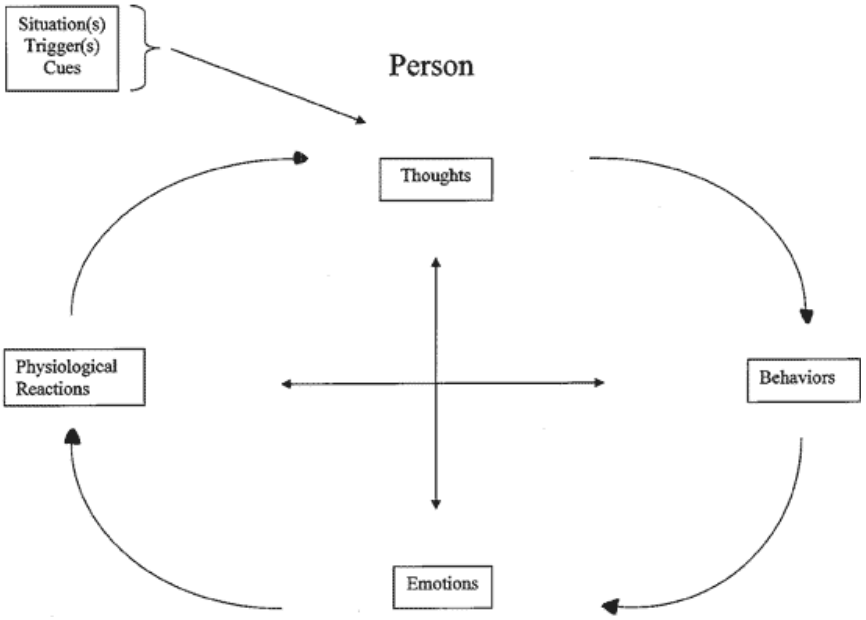


Figure 2. *Cross-sectional model of CBT.*[71]

'As we can see in this model', the lecturer pointed to each of the four rubrics labelled 'thoughts', 'behaviours', 'emotions' and 'physiological reactions', 'in general psychological terms, we all consist of four primary functions and CBT deals with each of them.' He continued:

> Now, there exists a constant interaction between these functions, and – zooming out – between a person and his or her environment. Our environments entail triggers and cues, and these are the inputs that get processed as we go about living our lives.

He explained that 'environments' were 'full of information, dangers, and surprises.' In this model of the world, 'the events or situations we are confronted with in our environment trigger our thoughts and how we come to experience the world.' The lecturer looked around in the classroom to check that everyone was seemingly following him and explained that this point led us to 'cognition':

[71] Slightly different versions of this model can be found in the CBT literature, but the basic principles as described above are the same. All figures by permission of Psychology Tools (URL: http://psychology.tools/download-therapy-worksheets.html) © 2008-2014 Matthew Whalley.

> Human cognition generates thoughts or what we might also call "cognitive processes" in more technical terms; some of these processes are particularly ingrained and form part of what we in CBT calls "core beliefs" or "schemata".

Core beliefs, he expanded, referred to 'the central cognitive content or constructs that people hold about themselves, others and the world.' These were central to the therapeutic model of CBT: '… it's "the stuff" of therapy', we were told. But CBT necessarily meant the practitioner dealing in priority with 'a person's "negative" core beliefs, that is, the dysfunctional cognitive patterns that have become so ingrained that they lead to adverse behavioural habits and consequently emotional suffering.'

The lecturer presented his material in diagrams, which have become a hallmark of objectivity . The functions he described became objects with arrows between them that 'demonstrated' a relationship. Arrows connected four functions in a circular pattern (see Figure 2). We learnt that 'our behaviours are often determined by our thoughts and the beliefs we hold about ourselves and others.' In turn, our 'cognitive and behavioural habits affect the ways in which we emotionally process events – how we come to experience what happens to us.' It was stressed that this was a fundamental lesson in CBT: 'it is not the event itself that causes suffering, but our experience of the event.' The lecturer paused. The point he wished to convey here was that 'physical and emotional wellbeing rest on our cognitive and behavioural capacities to adapt to our environments in a positive way.' That was one reason 'why it's called *Cognitive Behavioural* Therapy.' He summed up: 'CBT is essentially about adjusting or changing maladaptive or dysfunctional cognitions and behaviours in order to thrive.'

The introductory classes thus teach students to conceptualise personhood through four 'primary functions' categorised as 'thoughts' (or 'cognition'), 'behaviours', 'emotions', and 'bodily sensations' (or 'physiological reactions' or simply 'the body'). Students are taught to think of these as distinct but 'interconnected' realities constituting what it means to be human in 'psychological terms'. There is a strong sense here, in the textbooks and in the classes, that we are dealing with universal human attributes. While the therapists might affirm that the 'content' of each function varies between 'individuals', in the content of individual 'thoughts', the categorical reality of 'thought' or 'cognition' as both function and structure assume human universality.[72] In addition to the four primary functions, students were instructed that 'human

[72] The language of 'content', 'function' and 'structure' in psychology is largely inherited from medicine.

beings inhabit environments that contain situations, events, triggers and cues'. The idea of 'human nature' vis-à-vis 'the environment' has a long history in psychology as in other disciplines where the nature/nurture dichotomy is still salient and is allowed to frame discussions.[73] 'Thoughts' or 'cognition' is usually given an elevated status in the diagrams, with 'emotion' often featuring at the bottom (see Figures 2 and 3). 'The environment' is placed external to the complex of the four functions. As illustrated by an arrow in the model, the environment affects the person primarily through 'cognition'. 'The environment' generates 'events' which 'trigger' cognitive processes or thoughts (which in turn give rise to behavioural, emotional and bodily reactions).

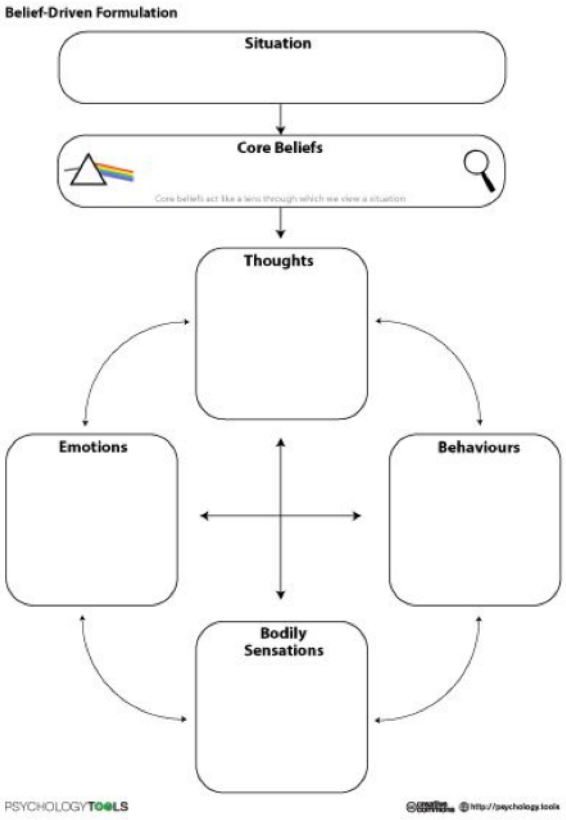


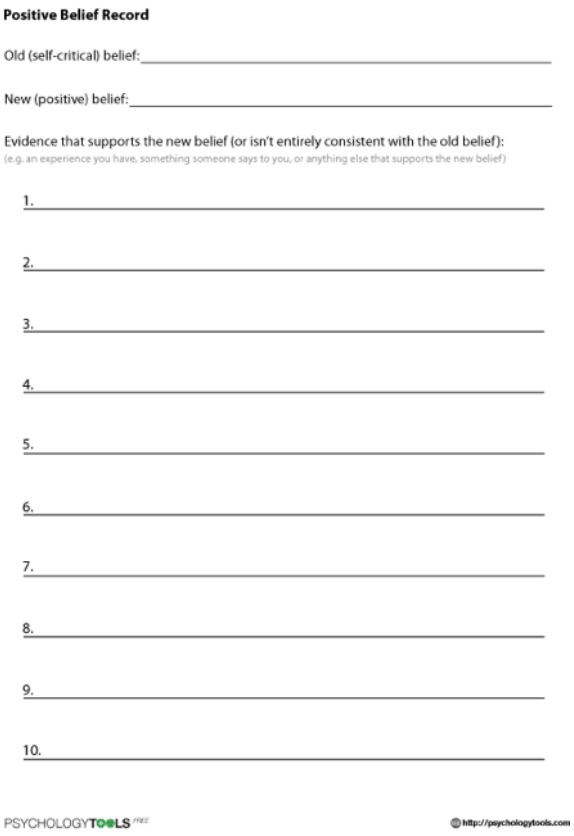
Figure 3. *Belief-Driven Formulation Model of CBT.*

The correlation between cognition and the environment is structured by a person's 'core beliefs' (the ingrained cognitive constructs that people hold about themselves or others).

[73] Anthropologists such as Christina Toren, educated in both psychology and anthropology, have long offered a critique of this nature/nurture or nature/culture dichotomy, which nowhere figures with any analytical status in her own approach (see e.g. 1990, 2012a).

Thoughts are understood to be influenced by the core beliefs that get 'activated' or 'triggered' by events or situations (see Figure 2). Students are taught that a person's core beliefs give rise to 'cognitive patterns', that is, the particular and entrenched ways in which a person processes and interprets inputs from the world. Cognitive patterns are understood to be 'wired' into the brain of a person. It is the 'core beliefs' that are the focus of much CBT work: by adjusting or changing a core belief that causes negative (behavioural, emotional, physiological) reactions, the person can develop healthier cognitive patterns. Core beliefs are adjusted or changed through 'rational inspection'. This is usually done in collaboration with a therapist who teaches the patient to challenge their 'irrational' or 'maladaptive' beliefs in order to overcome negative behavioural, emotional and physiological responses. Because of the perceived 'ingrained' nature of our core beliefs, challenging them is understood to be a difficult and gradual process, and one which requires practical repetition. The person must learn to practise new 'cognitive habits' that will result in healthier cognitive patterns, causing positive instead of negative 'feedback'.

In the classes, when learning this model, students are encouraged to use themselves as exemplars of how the four functions work and the significance of core beliefs. The first step is to 'identify' the core beliefs that are maladaptive and lead to negative responses, such as feelings of sadness and anxiety or behaviours such as withdrawal or aggression, including any sensation that might be registered in 'the body'. When a core belief is identified by the patient and therapist, it is often condensed down to an underlying self-statement, for example: 'I am unlovable'. The next step is to rationally 'evaluate' and 'challenge' the core belief. This is often done by means of questioning, perhaps by asking 'What experiences do I have that prove that this assumption is not true?'. The patient is then asked to note down all experiences that would challenge the core belief 'I am unlovable'. The underlying assumption of the negative core belief is systematically examined by recording any 'evidence' which is inconsistent with it. This evidence or information is rendered into new 'positive' or 'balanced' core beliefs and these are written down in a 'belief record' or 'positive data log' (see Figure 4).



Positive Belief Record

Old (self-critical) belief: _____

New (positive) belief: _____

Evidence that supports the new belief (or isn't entirely consistent with the old belief):
(e.g. an experience you have, something someone says to you, or anything else that supports the new belief)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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Figure 4. *Positive Beliefs Record.*

Thus, in CBT, patients are asked to observe and evaluate the *contents* of their thoughts ('negative core beliefs') in order to challenge them so they can be changed or adjusted to what is perceived to be more adaptive cognitive patterns ('positive core beliefs'). The therapeutic relief is seen to reside in a self-consciously rational conception and enactment of new 'cognitive habits'. The 'behavioural' component here means instantiating these new cognitions *in practice* through various exercises.[74] Students are taught that 'balanced beliefs' require 'careful nurturing' and 'self-affirmation'. As one lecturer told us: 'affirm yourself by using positive self-statements, remind yourself of all the evidence against the unhelpful core belief.' Gradually, through continued practice, these new core beliefs are understood to be integrated into the person's 'belief system', creating more 'positive' patterns of cognition.

[74] That is, the patient is progressively exposed to certain 'events' or 'situations' that are seen to trigger and reinforce negative beliefs or ruminations (e.g. a person who is diagnosed as suffering from social anxiety will gradually be asked to act out certain 'behaviours' in social contexts that are believed to trigger and reinforce a set of negative beliefs that cause the anxiety).

For the many students who had trained as Psychological Wellbeing Practitioners, and those who formerly worked in another therapeutic context such as psychiatry, becoming a CBT therapist involved a process of unlearning former models of therapy. This was at times a difficult process, not least because the 'models' presented by CBT were felt to subvert existing modes of therapeutic engagement and clinical skills previously acquired by the students. A few expressed their excitement about the fact that what they had practised in their previous professional capacity as therapists, and especially the 'theory' on which such practice was based, were taken up and criticised extensively in some of the classes, often for their many 'inadequacies'. The students had to 'step up' their competencies and apply models of intervention thoroughly tested and 'evidence-based'. Others, however, were visibly concerned, and some questioned the value of their former therapeutic work as Psychological Wellbeing Practitioners. These students felt somewhat betrayed by the promises of the IAPT programme to provide adequate training in evidence-based, therapeutic practice; they felt that the quality of therapy had been dispensed with as a result.

When such unease was articulated by students who had first trained as Psychological Wellbeing Practitioners in IAPT (to which they wished to return as CBT therapists), the lecturer would often remind them that models of intervention commonly used by Psychological Wellbeing Practitioners or 'Low Intensity' therapists were simply built upon with more 'complex' and 'advanced' theory and practice applicable to 'High Intensity' therapists. We were now learning 'real CBT', the lecturer explained, not a 'watered-down version' of it. This new teaching could then be incorporated as a natural learning curve from the simple to the complex, building up layers of therapeutic competence and skills appropriate for the expert role of the CBT therapist. Therefore, the models of theory and practice that many students had carefully exercised in their former therapeutic profession had to give way to more 'authoritative knowledge' – to more complex models of patients and treatments, and of CBT itself. However, an unease was voiced by students who felt nevertheless that their previous work as Psychological Wellbeing Practitioners was undermined by what they were now learning on the CBT course: they worried if they had, in fact, been practising CBT at all.

'Human psychology': acquiring a diagrammatic vision

Throughout the lectures and seminars, we were regularly instructed in CBT models of therapy. We would in turn learn to refer back to these models, where appropriate, in discussions of

patients or any problem we were trying to understand. These models were deemed, ethnographically here, to be 'representations' of reality, but they were also to shape that reality.[75] The cross-sectional CBT model (see Figure 2) was the principal referent. When put to work in this way, diagrams are talked about by practitioners as 'representations' that inform or explain different aspects of the practice of CBT. This kind of therapeutic training draws then on a scientific pedagogy which constructs universalised representations of its working objects through specific technologies of visualisation and standardisation. The model draws together a selection of categories (or 'phenomena', in psychological terms) and puts them in relation to one another. In the CBT diagram, the categories of 'cognition', 'emotion', 'behaviour', 'the body', and so forth, appear in correlation and retain the same position, which means that each category is also contained within a strictly organised semantic arrangement. The meaning of 'cognition' is constituted, therefore, in and through its relationship with other categories such as 'environment'. Diagrammatic representations of this kind make up a semantic network that students have to learn. The CBT model aims to constitute and account for a universal object which is perceived to be at once scientifically knowable and therapeutically workable: 'human psychology'.

The students thus learn 'the nature of human psychology' through a range of visual representations as illustrated in the scientific literature and in the lectures where models are drawn on a whiteboard or displayed in PowerPoint presentations. The models are usually two-dimensional, chart-like diagrams. In psychology, the use of diagrams is part of the practice of objectivity, as it is elsewhere. The use of diagrams is also an important part of a simplification process that is common in the production of scientific working objects (see e.g. McDonald 2014; Prentice 2005; Hallam 2013). Simplification in the form of a diagram is fundamentally visual (see Coopmans et al 2014), but psychological diagrams are usually accompanied by words: the charts, lines and figures are inscribed. Diagrams might simplify, but they are rarely self-explanatory and will often require further written or verbal explication in the classroom.

Over the course of these classes, we were presented with more and more complex diagrams. These represented psychological therapy in practice, both disorders and treatments, or therapeutic processes and their theorisation. Such diagrams are often accompanied by lengthy elaboration in textbooks or by instructing lecturers. The persuasiveness of the diagram lies in

[75] This is a common but important point noted about scientific practice in anthropological studies of science, see e.g. Cohn 2004; Edwards et al. (2007); Candea (2016); McDonald (2012); Coopmans et al. (2014).

how the representation comes to 'fit' the reality it seeks to represent; the extent to which the representation seems so self-evident.

The use of diagrams as a representational device in the sciences was a result of scientific image-making that developed in the nineteenth century and which became instructive in the invention of a particular kind of 'aperspectival' objectivity (Daston & Galison 2007: 123). The two-dimensional diagram has no shadows, suggesting a view from nowhere (McDonald 2014: 132). The diagrammatic vision implies a disembodied or transcendental vision, seeing everything from nowhere – what Haraway calls the 'god-trick' of scientific objectivity (Haraway 1988: 581). The invention of 'a-view-from-nowhere' objectivity, in which diagrams played a significant role, gave further impetus to the notions of scientific distance and detachment on the part of the scientist-as-observer. This was, and is still, an epistemic stance, or 'epistemic virtue' we might say (cf. Daston & Galison 2007), that sought to eradicate 'subjectivity' and 'particularity' as defined in opposition to 'objectivity' and 'universality'. We turn to these inventions in the context of evidence-based therapy in much more detail in the next chapter (see Chapter 5). In the meantime, we might want to note here that CBT diagrams bring these epistemic ideals together – objectivity, universality, and detachment – in their depiction of complex, epistemic objects such as 'human psychology'.

Throughout the therapeutic training, this epistemic object takes various forms. Importantly, 'human psychology' here refers not to the discipline of psychology but to the object of study: namely, the psychological traits of the human species. The universalist and biological terms are deliberate and very much part of what students are learning when studying psychology through the lens of CBT. The categories of 'mind' or 'cognition' can be said to emerge here as aspects of what it means to be human in psychological terms – that is, they feature as *constituent parts* of human psychology. And yet these various abstractions were not always discussed or enacted in precisely these terms. Theoretical concepts were often brushed off as being too far removed from the nitty-gritty of clinical work. However, all the diagrammatic representations that were used every working day – themselves often highly theoretical and abstract – were seldom questioned in the same way. It appeared instead to be the therapeutic language that put these diagrams to work in clinical contexts which had to reflect a commitment to the more practical and concrete reality of 'doing CBT'. In the supervision, as in the classroom, we learned to simply talk of 'mental illness', 'people' and 'patients', drawing our attention to the diagrams as models of the therapeutic object, subject and process.

'What is wrong with the patient?'

CBT therapists, like medical doctors and psychiatrists, are taught that treatment follows from 'diagnosis'. Providing the right kind of treatment means giving the right diagnosis. Without a diagnosis it is uncertain what exactly is being treated. 'What is wrong with the patient?' is the basic diagnostic question, and the answer dictates the therapeutic intervention. CBT students are trained to answer this question, but this is not always an easy task, even with many years of experience working with psychotherapy. Over the course of my fieldwork it became apparent that the word 'diagnosis' was sometimes felt to be inappropriate – 'too medical'. Some therapists told me they were wary of a 'diagnostic approach' as it restrained the therapeutic encounter in ways that inhibited the effectiveness and value of psychotherapy.

One of the psychologists, a former practitioner in the IAPT service who had left to establish her own private practice, was passionately opposed to the idea that psychotherapists should be diagnostic practitioners in the style of physicians. 'Diagnosis often results in the therapist approaching their patient as a diagnostic category rather than a person', she told me. Diagnosis evoked a world in which 'the patient becomes "depression" or "depressive symptoms" rather than an individual with a history and a life which is more complex than a diagnostic label or a set of symptoms.' Instead, this therapist wanted to meet 'patients on their own terms – and to really understand what you're dealing with you need to *meet the person*.'

In some ways, this is evocative of a common critique of diagnosis within primary care medicine in the UK, in which 'the whole person' is sought rather than the 'patient' with a diagnostic tag (see e.g. Mol et al. 2010). That 'person' or 'self' often remains elusive, however, posing therefore as a pervasive resource of critique and ambition (Bruun 2014), and it is apparently similar in this arena. A fuller understanding of the patients' 'suffering' is sought but only within the existing models, which necessarily constrain. Psychologists and psychotherapists often echoed to me the sentiment that a 'diagnosis' could prejudge and limit an encounter. In one of the supervisions, for instance, students were told that: 'if you give a diagnosis at the outset of the therapeutic encounter, you are forming a relationship with patients based on preconceived notions about the nature of their suffering.' However, within the institutional framework of the NHS in which evidence-based psychological therapy is provided,

failing or refusing to identify a patient's problems in diagnostic terms is more likely to be considered a breach of professional responsibility. The medico-legal demands of IAPT as a national public health service mean that diagnosis is deemed necessary in the provision of psychological therapy and it is actively sought in this context of mental healthcare.

Consequently, CBT therapists and all other IAPT psychotherapists are required to work diagnostically. In the classes I followed, a significant amount of CBT training involved learning to identify and evaluate symptoms and to classify them in order to arrive at a diagnostic category. This practice is generally referred to as 'assessment'. Assessment is intrinsically diagnostic. The therapist carries out an assessment as part of their first consultation with a patient. (Although an initial assessment, known as a 'screening call', and conducted by a Psychological Wellbeing Practitioner on the telephone, usually takes place prior to consultation with a CBT therapist.) The purpose of the assessment is to identify one or more 'mental health problems' or 'disorders' and to determine the severity of the patient's condition. This involves classifying a condition in accordance with three definitions of the degree of psychological acuteness: 'mild', 'moderate' or 'severe'. The assessment of the severity of the condition assigns the patient to one of three 'care pathways' or 'interventions' within the stepped-care model of IAPT. Assessing the severity of a condition is determined by three factors: 'symptom severity', 'duration of symptoms', and associated 'functional impairment', with the last here referring to the impairment of vocational, educational, social or economic functioning. According to NICE guidelines, the diagnostic classification of the severity of mental health problems is defined as follows:

1. *'Mild' generally refers to relatively few core symptoms (although sufficiently present to achieve a diagnosis), a limited duration and little impact on day-to-day functioning.*
2. *'Moderate' refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning.*
3. *'Severe' refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).*[76]

[76] As cited in NICE (2011: 45); this document provides an outline of the assessment procedure for 'common mental health problems'.

When CBT students are learning to assess patients, they are therefore learning to identify, in psychological terms, the nature of a pathological condition ('mental health problem' or 'disorder') by the examination of symptoms. Psychological assessment relies on the use of diagnostic categories of psychopathology which are determined by the publication of international diagnostic standards for teaching and treatment informed by the DSM-5 (*The Diagnostic and Statistical Manual of Mental Disorders 5th ed.*) – published by the American Psychiatric Association (2013) – and the ICD-10 (*The International Statistical Classification of Diseases and Related Health Problems 10th ed.*) published by the World Health Organization (2017). These two main publications – together with the professional conferences and institutional regulations that accompany them – stabilise and officialise international classification standards (cf. Bowker & Star 2000) for identifying different forms of 'mental disorder' which serve to establish a shared language of psychopathology across different mental healthcare professions.

In the National Health Service of which IAPT is part, therapists are required to conduct a psychological assessment then – using 'diagnostic identification tools'. These tools are algorithmic questionnaires and scales; they provide a diagnostic score following a calculation based on the quantification of answers to a set of questions. The use of scales and more general quantification are themselves marks of objectivity (Porter 2001, on 'trust in numbers'). The questionnaires as well as the scales deployed in IAPT have achieved scientific consensus as 'validated measures' for specific disorders. Learning to do 'assessment' in CBT involves then learning to use a set of questionnaires with a patient, to an objective end. In the UK, the 'validated measures' used to diagnose the two most common mental health problems – 'depression' and 'generalised anxiety disorder' – are the PHQ-9 [9-item Patient Health Questionnaire] and GAD-7 [7-item Generalized Anxiety Disorder scale]. Other mental health problems treated by CBT therapists, such as obsessive-compulsive disorder (OCD), social phobia (agoraphobia), health anxiety (hypochondria), panic disorder, and post-traumatic stress disorder (PTSD) each have their own 'measure'.[77]

The identification of disorders in CBT, as in clinical psychology and psychiatry, thus derives from the use of patient questionnaires where diagnoses are presented as a checklist of criteria. This is a particular technology of quantification. Questionnaires as numerical scales are

[77] For an outline of these patient questionnaires, see *The IAPT Data Handbook version 2.0.1 Appendices* (2011: 22-39).

designed to render a person's experience of suffering into an observable and measurable condition. The basic task of the questionnaire is to either confirm or disprove the existence of a disorder. Without the questionnaire, the question of 'what is wrong with the patient?' remains unanswerable and the patient's suspected condition escapes observation. It is perhaps not surprising, therefore, that to some untrained students who have not yet been exposed to and acquired the perceptive capacity of the assessment tools, 'psychopathology' ('the study and diagnosis of mental disorders') feels unnervingly 'ambiguous'. That is, 'mental disorders' often seem undiscernible to the novice practitioner. Anxiety and depression are not apparent and apprehensible in a way that a broken arm might be to a non-expert, nor are they as readily distinguishable as a fever is from a bleeding finger. However, over the course of psychotherapeutic training, ambiguity seems to disappear in practice. By the time students have completed their introductory classes and are well into the course, they have already assessed several patients, formulated diagnoses and treatment plans, and they are increasingly proficient in discerning a disorder immediately, as if they were inspecting a broken arm. The CBT students come to talk about 'mental health problems' and 'disorders' as if the assessment tools detected conditions that were both clearly observable and discrete entities.

Students learn this therapeutic epistemology through repeated practice in the classroom, in their sessions with patients, and in supervision. They learn to memorise and in turn perform the questions, the checklist of criteria and symptoms, the diagnostic scores, and so forth, and the accumulation of this learning process is the acquired ability to 'know' what is wrong with the patient. The students come to 'see' the problem or disorder with the certainty of the eyes of the measure (Cohn 2004; Luhrmann 2000). In this sense, the use of these measurement technologies is how therapists are 'doing' disorders (Mol 2002). The questionnaire becomes the reality of the disorder in practice by way of rendering 'it' visible and workable: human experience of distress becomes a quantity, a document, an observable object. This is how the students, by the time they have finished the CBT training, can see a patient for an incisive 20 minutes and with confidence conclude: 'you are suffering from moderate depression'.

Beyond 'talk therapy'

Psychotherapeutic care of the sort that CBT promotes has many shared features with psychodynamic psychotherapy (see Bruun 2014), one of which is the understanding of therapeutic treatment as an essentially heuristic and interpretive task: the therapist's job is to

enable another person to discover and learn something for themselves, and about themselves. In CBT and other IAPT therapies, this aspect of therapeutic work is commonly referred to as 'psycho-education' and 'guided self-help'. In a recursive manner, the training of CBT therapists is also intrinsically heuristic in these terms. For example, the teachers' job is to enable the students to discover and learn for themselves how to do CBT, what it means to work therapeutically, the effects of CBT on certain conditions, and so on. From this perspective, psychotherapeutic treatment can be understood as a highly interpretive exercise that works through the construction and use of narratives, and one which the therapist is meant to teach patients to do: it was stressed to us all in the classes that the patient, too, must learn, in a sense, to become a 'competent CBT therapist'. One of the purposes of CBT therapy was thus to enable patients to manage and change their 'negative beliefs' (the contents of their thoughts) through cognitive and behavioural techniques. However, we were frequently reminded that the purpose of therapy is not to 'get rid of negative thoughts', as it were, but to learn how to deal with them when they arise. It is often stressed that CBT does not restore you to a permanent state of 'wellbeing' but that it enables you to work with whatever challenges life throws at you. In this sense, CBT therapy teaches patients and practitioners alike to become 'their own therapist'.

These ideas are evocative of mainstream theories of the effectiveness of psychotherapy in both psychotherapeutic and anthropological writing about why psychotherapy might work, and why it might work well (when it works). In psychological and medical anthropologies, one dominant strand of this theorisation is known as 'symbolic healing' which looks at the relationship between narrative or ritual symbolism and healing in specific cultural contexts (Dow 1986). Another anthropological strand related to this work is the notion of 'narrative reasoning' and 'therapeutic emplotment' (Mattingly 1994). These approaches theorise (psycho)therapeutic practices as cultural modes of storytelling, as healing practices whose effectiveness works through symbolic and narrated imagery and plots. A central argument in the anthropological literature is that humans have a universal ability (and a propensity) to come to terms with what is variously described as their emotional and cognitive experiences – their inner world or sense of self – through an *external* rendering of this perceived internality. Such a stance would, in general terms, require us to theorise psychological therapy, or CBT more specifically, as a cultural and collaborative construction or reconstruction of a person in a narrative by means of a series of consultations that aim at providing appropriate externalisations

through which people can find and come to terms with the cause and meaning of their suffering.

Anthropological theorisation of this kind resonates with a number of conceptualisations of the therapeutic value of the use of symbols and different forms of narrative found in psychodynamic traditions (see e.g. Axline 1974; Winnicott 1971) including CBT (e.g. Rhodes 2014). Lévi-Strauss is credited with having brought this insight concerning the use of narrative and symbolic imagery to the fore in anthropology with his influential chapter entitled 'The Effectiveness of Symbols' (Lévi-Strauss 1963), which contains a comparative analysis of psychoanalysis and shamanism. Lévi-Strauss' central conclusion was that both the shaman and the psychoanalyst interpret and translate (albeit in different ways) their patients' feelings, experiences or sensations into words and symbols in order to manipulate them; a process in which therapeutic relief is achieved through the very effectiveness of 'external' symbols. Lévi-Strauss' theory has been revised and elaborated by anthropologists studying different contexts of the (psycho)therapeutic as particular cultural discourses that construct and work through the symbolic, the narrative and the mythic (e.g. Calabrese 2008; Davies 2009; Dow 1986; Mattingly 1994). In these ethnographies, therapists (and their patients) tend to become narrators, symbolists and interpretivists par excellence. Many such approaches often contribute, therefore, to a vision of psychotherapists as skilled in the performance of 'externalisations' – namely storytelling, plots and symbols – of some sort of internal, individualised subjectivity or 'inner world' where emotions and thoughts are located. They often imply, much like Levi-Strauss, that the effectiveness of psychotherapy is inherently symbolic and lies in the story.[78]

I do not wish to dismiss the ethnographic significance of the narrative and the symbolic as a way of understanding psychotherapy.[79] However, I want to suggest that there is more going on in the training and practice of psychotherapy in both empirical and theoretical terms. There is more to psychological therapy ethnographically than 'talk therapy', and analytical overemphasis

[78] There are many (psychological) anthropologists writing in this psychoanalytic or Levi-Straussian vein; I quote Tanya Luhrmann (1989: 249) here as an example: '[Psycho]therapy seems to work when someone externalises, or labels, some internal feeling and then is able to transform it … Narratives could be therapeutic because of the way in which someone finds a central character or symbol moving, the way in which they identify with it. The person would imagine herself as that character by using her own experience as the ground. … If that character has emotions which you have repressed within you, your identification may help you experience these feelings more directly. … The narrative then becomes the practice-ground, a dry-run to handle feelings and responses in new ways.'

[79] I have explored some aspects of this elsewhere (see Bruun 2013).

in anthropology on narrative is not always a helpful approach. Psychotherapists are not simply learning to 'talk' as it were (and neither are patients); learning to be therapeutic and to work therapeutically involves dynamic processes that are rather more complicated, taking us beyond narration, symbolic healing, and emplotment.

Articulating bodies

Becoming a skilled therapist requires apprenticeship in a particular learning environment. I have indicated earlier that we might understand the training of therapists as a form of 'situated learning' (Lave & Wenger 1991). It should be noted, however, that the concept of 'situated' learning does not refer merely to how people are located in space and time, as Lave and Wenger make clear (1991: 33). Nor is it simply a term for 'social' action in the sense of involving other people and specific settings. Acquiring knowledge and skills is, of course, a process constituted in shared contexts (demarcated temporally and spatially) that occasion ways of learning. My approach takes such general theoretical assertions further.

Approaching learning as 'situated' aims to reveal the intrinsically relational feature of knowledge acquisition and attends to how meaning takes shape in activities at once practical and conceptual, in which contradictions or tensions require careful negotiation and coordination. There is no activity that can be said to be unsituated (Haraway 1988; Mol 2002) or not historical (Toren 2012b). Learning is not a transmission of 'mental representations' or a matter of innate 'cognitive predispositions', and it is certainly not an activity in which a discrete brain-subject simply 'receives', 'processes' and 'applies' knowledge about the world *as it is.*[80] Such computational, evolutionist and cognitivist ideas are rejected here (for anthropological critiques on some of these points, see Laidlaw 2007; Toren & Pina-Cabral 2011). What it means to learn, to acquire skills, and to engage others in processes of skilled learning and knowledge acquisition cannot be reduced to a set of genetically modulated cognitive mechanisms, dedicated to discrete computational tasks, even if this framework has become particularly persuasive to some psychologists and anthropologists alike (cf. Whitehouse 2001), as metaphors of 'knowledge', 'the brain' and 'computers' have joined forces (Cohn 2004, 2009;

[80] Such and similar assumptions are foundational to theories of learning, especially in cognitive anthropology where many of these ideas are owed to evolutionary psychology. For anthropological examples, see e.g. chapters by D. Sperber and P. Boyer in Whitehouse (2001). For critical reflections on cognitive science vis-à-vis social anthropology, see Laidlaw (2007).

Dumit 2004; Rose & Abi-Rached 2013). We might instead theorise learning as an activity in and with the world, which entails learner(s) and teacher(s) and all circumstances of the learning environment as mutually constitutive. Even the acquisition of knowledge in the form of an abstraction – 'human psychology' – is itself a practical configuration reliant on specific technologies of learning in specific circumstances.

Becoming skilled in psychological therapy then is the result of ongoing training and experience in the engagement and enactment of a particular activity in which all implicated circumstances constitute what it means to work therapeutically. Some therapists might in their own terms say that to learn to do psychological therapy is a matter of an individual student developing 'competencies' specific to a clinical context or problem, including 'social and cultural competencies' ; an understanding that has not differed greatly from anthropological analyses of professional learning in clinical settings (e.g. Kleinman 1980). However, to this anthropologist, becoming a psychotherapist is not simply a case of individuals developing 'competencies' or a set of professional skills achieved through institutional 'socialisation' or 'cultures', as anthropologists of psychotherapy have suggested elsewhere (cf. Davies 2009, on institutional 'socialisation'; Luhrmann 2000, on professional 'cultures'). The capacity to develop such 'competencies' means acquiring a particular body that is learning, and has learnt, to be affected (Latour 2004a) by the circumstances of therapy. Drawing in part on the work of Isabelle Stengers (1997) and Vinciane Despret (1999), as well as William James' 'radical empiricism' (1976 [1906]), Latour argues:

> To have a body is *to learn to be affected,* meaning 'effectuated', moved, put into motion by other entities, humans and non-humans. [The body is] *an interface that becomes more and more describable as it learns to be affected by more and more elements.* The body is thus not a provisional residence of something superior – an immortal soul, the universal or thought – but what leaves a dynamic trajectory by which we learn to register and become sensitive to what the world is made of. (Latour 2004: 205-206; original emphasis)

Latour rephrases this approach through an ethnographic study (Teil 1998) in which the use of odour kits constitutes the training of 'noses' in the French perfume industry. The odour kit consists of distinct pure fragrances in an arrangement of sharp and subtle contrasts and differences. The training sessions, the teacher and the kit provide the conditions and circumstances for learning to register and differentiate between more and more subtle differences in odours, thus ultimately becoming 'a nose'. That is, the trainee becomes a nose

(*un nez*), as it were, as the trainee acquires a refined sense of smell that defines her ability and skill in detecting and producing olfactory compositions. 'Acquiring a body', as Latour writes, 'is thus a progressive enterprise that produces at once a sensory medium *and* a sensitive world' (2004: 207; original emphasis). The therapist must learn to be affected by the specificities of what it means to work therapeutically. This demands an affective engagement of the body which takes discipline and practice.

Rather than being a case of cultural or institutional socialisation then, learning to be therapeutic and to work therapeutically is a process of *mutual* articulation (McDonald 2014; Prentice 2005): therapists learn to be affected in the mutual articulation of both concrete and conceptual 'working objects' from diagrams and protocols to client cases and patients, their own bodies included. The patient and the therapist, especially, constitute each other in significant ways. Mutual articulation describes an affective and material process of co-constitution, a mutual articulation of circumstances and therapist in the specificities effected in the learning environment of psychotherapy. In the words of Latour (2004), we might say that before the CBT training, the therapists were 'inarticulate'; both in the sense of their inability to see and speak psychotherapeutically, and in the sense that they had not yet learned to be affected by their teachers, colleagues and other 'circumstances', including books, paperwork and other objects in the course. They were thus unable to 'think', 'listen', 'perform', and so on, as a CBT therapist. The trainee therapists could be said to acquire new bodies by becoming more sensitive to ever keener distinctions that the world thereby affords them. In the psychotherapeutic environment, these distinctions are themselves rendered articulate in the theories, models, consultations, records, colleagues, clinical guidelines, and everything else that make up 'CBT'.

In the world of psychotherapy, 'supervisions' are thought to be one of the most important educational settings for therapeutic training. Supervisions can take the form of a group session or a one-to-one meeting and a qualified CBT therapist leads both types of supervision. The weekly supervision is designed primarily to evaluate the students' clinical practice with their patients and to address the therapeutic issues that arise in consultations. The trainee therapist is asked to take detailed notes of each consultation and this is done routinely after seeing a patient. Notes are written down in a confidential 'patient journal' that the trainee brings to supervisions. Various clinical topics and intervention practices are discussed throughout the supervision that relate to the patient cases at hand, such as the appropriate treatment for 'chronic depression' or how to deal with 'complex patients', and students might be instructed in

'transdiagnostic practice' or the facilitation of 'emotional regulation', 'goal-setting', 'relapse prevention', and so forth. The supervision ideally brings all the specificities of psychological therapy together within a structured space and time.

In the supervisions, the students consult their notebooks and patient journals to recount their therapeutic sessions. They might move from their present patient case back to past sessions or cases to detect differences and similarities. They relate these in turn to the accounts presented in the clinical textbooks, by their colleagues in the group and by the supervisor. Analogous to McDonald's (2014) medical students and their 'working objects' in anatomical dissection and Prentice's (2005) surgeons and their 'instruments' in surgical sculpting, the CBT students learn to work therapeutically at the interface of their own bodies and the instruments of psychological therapy. They move from one medium to another: notebooks, guidelines and diagrams are consulted, and they move comparatively between patient cases and accounts that circulate in the supervision group and in the clinical literature. The 'working objects' of this learning environment – all the notes, schemas, video recordings, patient journals, including the supervisor and colleagues (and much more) – become part of what it means to become a therapist, to acquire a body that knows what it is 'to be therapeutic'. CBT students thus learn progressively to be affected by the materials that are instrumental in constituting 'competency' and 'skill' in sessions and supervisions, and they do so relationally with other therapists, supervisors, and patients.

Working 'therapeutically' in practice, then, ideally confirms the models or theories on which knowledge and skill are seen to rest. The students are learning to identify aetiologies and pathologies; that means learning to pay attention to what is significant (literally) and putting it in context. The teacher is drawing the students' attention to 'patterns', 'traits', 'qualities', 'features' and 'characteristics' of 'disorders', of 'personalities', and of CBT 'interventions'. In the supervision, as in the therapeutic session, paying attention involves the ability to grasp and conceptualise these distinctions, a task effected through various classifications and scales, already acquired by the students in the learning environment of the classroom.

Participation in the supervision group demands a capacity on the part of the student to be 'reflexive' about their therapeutic work.[81] 'It's in supervisions that we really develop as therapists', announced the supervisor in one of our first group supervisions. 'Becoming a good therapist

[81] On the question of reflexivity, see Chapter 6.

requires introspection and the willingness to apply to ourselves the same knowledge and techniques [from CBT] that we ask our patients to apply to their lives, and to learn from.' The supervision is talked about as a 'safe space' where the trainees can share experiences and learn from failures and successes: 'we are all vulnerable in supervisions', as one supervisor put it. Sharing experiences and interpretations, perceived failures and successes, and the agreement on what constitutes error or progress, figure clinically as 'observations' in psychotherapy and may be perceived, in their own terms, as strictly 'clinical' but also as 'personal' or 'anecdotal' in quality. Conversation is framed using the appropriate conceptual language of CBT as printed in the textbooks and spoken by the supervisor; when students at times failed to put this language to work, they were guided to rethink and reformulate an observation. We were reminded to 'be therapeutic'.

chapter five

Throwing out the psyche

In pursuit of a science of psychotherapy

We move now from the training of therapists to the rather different context of conferences in which evidence-based psychological therapy is presented and discussed amongst professionals. These conferences offered important contexts in which 'scientific research' and the 'evidence' it offered were mobilised, engaged with, and understood. Conferences might be seen as part of a machinery of fact production in which, as sociologies and anthropologies of science have noted (see Edwards et al. 2007; McDonald 2012a; Candea 2016), the important 'evidence' that goes towards the making of facts is agreed or disputed. They can thus be thought of as a form of secondary peer review. I will expand on some of these points in the following paragraphs.

Although they might be said to end up as a practice of this kind, the professional conferences I attended were not intended by their organisers to be the primary sites of evidence production but sites in which evidential material could be presented and further discussed. The account I present differs in some important respects therefore from an anthropology of science carried out 'in the lab' or research unit, where ethnographers might expect to find science 'in action' (Latour 1987). 'Laboratory ethnography' of this kind has in many ways laid the ground for both Science and Technology Studies (STS) and anthropological studies of science, and it remains instructive here. However, this chapter (and the thesis as a whole) could be said to be more about what is subsequently made of the story of scientific research or fact production, not the story itself.[82] It is of course the researchers and scientists (including other implicated technologies and circumstances, human and non-human) who construct and conduct the experiments from which the 'evidence-base' of psychological therapies can be demonstrated, but it is the practising therapists and mental health professionals at large who have to be persuaded. It is the latter who consume the scientific facts produced and transform the status of evidence, who make therapeutic practices 'evidence-based', mobilising clinical programmes and action, incorporating certain facts for different purposes and disregarding others, and so on. Conferences are thus spaces in which a reliable 'science of psychotherapy' for which the basic science had already been done somewhere else, was intensely and obviously sought, albeit

[82] My point is partly inspired by my reading of Latour and Woolgar's postscript in the second edition of *Laboratory Life* (Latour & Woolgar 1986), although they are making a (somewhat different) point about reflexivity; about the production of their own account or story and 'what is subsequently made of [it]' (ibid: 284).

not without contention. A failure or reluctance to be persuaded by this pursuit of scientific evidence and endorsement prompted moral disapproval.

This chapter touches on three main points. The first point is about ethnographic definition and self-definition: practitioners of evidence-based psychological therapy are well-rehearsed in a moral discourse, as we shall see in a moment, of professional self-definition. [83] 'Psychoanalysis' remains one category against which CBT has defined itself as 'real science', but it is also through this and related us/them boundaries that a problematic 'gap' between science and practice, or scientists and practitioners, has been forged and confirmed. Not all members of the category of 'evidence-based' practice are equally 'evidence-based' in the self-image of what counts as real science.

The second point touches on historical inventions and reinventions of 'objectivity'. We will be looking at how the general epistemological framework of EBM has offered scientific legitimacy to, and justification for, psychotherapy and, in turn, how evidence-based psychotherapy has become constitutive of what I call 'evidential objectivity'.

The third point I wish to make is that the very practice of psychotherapy has long posed problems for psychologists in their pursuit of a 'science of psychotherapy'. One such pursuit, and we will see this throughout, has involved the tacit but persuasive metaphor of the 'pill' or 'medication' as the epitome of a therapeutic intervention residing unequivocally in the realm of objective science. Proponents of psychological therapy, I suggest, have long sought recognition for it as the product of science, but crucially with 'subjectivity' as its scientific object. Psychological therapy could be said to have finally achieved such recognition, at least in the UK, but it is also because of this achievement that empirical tensions continue to loom large.

We could say that shaping psychotherapy into an object of scientific inquiry has been a preoccupation of psychologists since the early days of its conception. Freud himself famously sought to place psychoanalysis on an equal footing with medical science (Freud was, after all, medically trained in nineteenth-century 'physiology' and 'neuropathology'). Psychoanalysis was never successful, as we now know, in achieving the kind of scientific recognition Freud had imagined, although psychoanalytic psychotherapy did appear to gain, during the mid-twentieth

[83] In making this point, I draw widely on the work of Ardener 1982; Chapman 1978; McDonald 1989; Herzfeld 1989; Candea 2010.

century, a prominent clinical standing in the discipline of psychiatry across Europe and, especially, within American psychiatry of the 1950s and 60s (Luhrmann 2000; Marks 2017, 2018a, 2018b). The critique of clinical judgement and decision-making in medicine that emerged in the late 1960s and 1970s (cf. Feinstein 1967; Cochrane 1973) laid the foundation for a movement that later became known as evidence-based medicine (EBM) in the 1990s (Lambert et al. 2006; Timmermans & Berg 2003).

It is through the influence and recensions of the EBM movement that psychotherapy in the form of CBT (and related therapies) has been seen to achieve its scientific status (see e.g. David et al. 2018; Parry 2000; Rowland & Goss 2000).[84] A range of regulatory bodies in the UK now stipulate 'evidence-based' practice across different sectors from medicine and public health to urban planning, education, nursing, and economics – and right back to the national regulatory bodies themselves: the 'evidence-based' practice of mental health policy-making and implementation (see e.g. Department of Health 2015). The list of disciplines and areas of expertise that now lay claim to evidence-based practice is long and proliferating (Trinder & Reynolds 2000; Goldenberg 2006).

We turn first to the conferences themselves.[85] Conferences in psychology have become important occasions for the dissemination of new research that can inform clinical practice. They have become instrumental in shaping 'evidence' for the formulation and establishment of 'standards' of clinical training and 'good practice' across a range of healthcare professions. They have, in other words, become important regulatory events in 'the generation and management of evidence' (Cambrosio et al. 2006). Conferences are therefore interesting ethnographic sites in which 'evidence-based therapy' is constituted as a scientific activity – and through which notions of 'science' and 'objectivity' are shaped. We will then look at the invention (and some reinventions) of 'objectivity', after which we turn to the question of its opposite, 'subjectivity', and reflect on the ways in which the two have been separated, and then brought together, in the construction of a science of psychotherapy.[86]

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[84] Psychotherapy has since claimed its own label as evidence-based (psycho)therapy (EBT).

[85] The material in this chapter is taken primarily from fieldwork carried out in conferences and meetings where research on evidence-based psychological therapies was presented and discussed. Some conferences focussed on 'clinical' and 'work-related' issues in the IAPT service, including the training of IAPT professionals (especially Psychological Wellbeing Practitioners [PWPs], CBT and Mindfulness therapists), whilst other conferences concerned the 'implementation plans' of new mental healthcare initiatives, strategies and technologies in the NHS.

[86] I am aware that we will pass through details in this chapter that might seem rather 'theoretical' to some

The professional conference

Conferences have become instrumental in the practical achievement of the constitution of an evidence-based psychological therapy and its professional practitioners: therapists are expected to attend conferences and related events in which 'the latest research' is presented and often presented in such a way to be 'applied' in clinical practice. In an important sense, the 'conference' is reified, as we shall see in the following, as the uniting ground of supposedly separate domains – 'the science' and 'the clinic', or 'research' and 'practice'.

The annual conference of The British Association of Behavioural and Cognitive Psychotherapies (BABCP) is one of the largest professional CBT conferences in Europe. It is also considered one of the most prominent conferences for researchers and practitioners engaged in evidence-based research on psychological therapies. Although CBT remains central to this annual conference, the research topics of the conference are diverse and cover a wide range of disciplines. The conference takes place over five days, each year in a different city in the UK. It attracts over one thousand delegates, with over 300 presentations with additional seminars such as 'clinical round tables' and 'skills classes'. The BABCP conferences I attended also hosted exhibitions of fresh-off-the-press research posters, and stalls were set up by private healthcare companies whose research and products were on display for the duration of the conference. Although the conference is organised primarily for professional members of the Association in the UK, and attendance is part of their constitution as 'professional', attendees fly in from all over Europe and abroad.

The self-defined professionals who attend these conferences tend to describe themselves as either researchers and scientists or as clinicians and therapists. 'Clinician' or 'therapist' refer to those who primarily work with people therapeutically ('clinical work') or those who simply work in a clinic (e.g. hospitals, healthcare centres, or in 'private practice'). These terms are therefore used to distinguish between those who primarily conduct scientific research and those who treat 'patients'. This professional division between researchers, on the one hand, and clinicians, on the other, is a common but often a misleading one, I was told, since many so-called clinicians are engaged in research projects and, conversely, some researchers spend a great deal of their working hours doing clinical work. Psychological research is typically carried

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readers, but all this 'theory' is very much part of the ethnographic material I collected through fieldwork; it is part of the scientific epistemology that is being put to work in the IAPT service and elsewhere.

out in clinical settings, with patients; even when this is not the case, research projects typically draw on 'clinical data' provided by hospitals and other clinics. The term 'clinical researcher' has taken care of some of this mismatch. It is a title now commonly used by professionals in psychology who primarily identify as scientists but focus on specific 'clinical' objectives.

The conferences I attended attracted clinical psychologists and psychiatrists, neuroscientists, nurses and various other healthcare practitioners, including, of course, CBT therapists, as well as other psychotherapists dealing with cognitive and behavioural therapies. They were meetings in which most attendees acted as academic colleagues, even if they were not. Contrary to the NHS conferences I had likewise attended, the professional CBT conferences were arenas in which critique and critical input were actively encouraged. The atmosphere was ambitious and competitive, but also collegial. Attendees talked about conferences as if they offered a direct window on to the latest evidence-based research. Not only did these conferences appeal to the kind of mental health professional who wanted to keep up, as it were, with 'new evidence' in their respective fields, employers (such as IAPT service providers or university clinics) also increasingly *required* attendance. It was thus generally assumed that conferences provided an educational means through which to both report on, and learn from, 'scientific research'. Many professionals I met at these conferences were actively encouraged by their workplace to attend, with employers providing the conference funding for their delegates (the price of conference registration ranging from £400–500 per person [with one-day conferences in the range of £150–250] at the time of fieldwork). Attending conferences was clearly a marker of 'professionalism' and regular attendance marked out the serious professional. Such a professional is striving to be a scientist-practitioner – an ideal inherited from psychiatry and medicine, but one that has become tremendously important in the practice of psychotherapy since the introduction of EBM in the early 1990s. We return to this ideal in a moment.

This annual conference is also advertised as a 'social' event – with the 'social' external to the formally presented science – for professionals 'to meet and mingle'. The conference programme includes an extensive timetable of 'social entertainment', complete with a party in a rented nightclub and music by the BABCP's own members' band.

When mental health professionals arrive at these conferences, they are generally already accepting of the premises of evidence-based research, even if they are not knowledgeable about how exactly such research is conducted. The specificities of the methods and protocols involved

in evidence-based research are in many ways incomprehensible to outsiders, other than the researchers themselves. In saying this, I do not mean to suggest that there by any means exists an intrinsic ordering of knowledge or intelligence between scientists and therapists whereby the latter fail to apprehend the scientificity of the former; nor do I mean to imply a succession of complexity from 'clinical work' through to 'scientific research' at the highest level, although it is significant that some professionals appeared to suggest this.

Rather, the ethnographic point here is that the majority of psychotherapists are not trained in the evidence-based research which is understood to undergird their clinical practices. Therapists are in other words not trained as psychological scientists, even if they are increasingly expected to work and talk like them. Importantly, his means that therapists have not designed or performed the randomised control trials (RCTs) from which the 'evidence-base' of their psychological intervention is understood to have been drawn. The hundreds of healthcare professionals who attend these conferences do not themselves have the necessary specialised skills to construct or scrutinise the technicalities on which 'RCTs', 'meta-analyses' and 'systematic reviews' rest – the epistemic trio that are seen to make up 'evidence-based' research. It is nevertheless this complex package of research – the science fresh out of the psychological laboratory as it were – which is seen as the most important and exciting aspect of the conference, and it is what attending healthcare professionals expect to get from their attendance and bring home to the clinic.

The words that mark out these conferences are 'science' and 'research'. Not unlike other disciplines, psychological 'research' or 'data' are deemed either 'good' or 'bad', as in the case of psychiatric science (Luhrmann 2000: 160–161). Research is either convincingly 'robust' and 'rigorous' or deemed 'weak' and 'flawed'. Anthropologists are familiar with a similar evaluation of their own evidential practices whereby ethnography gets qualified through a moral language such as 'deep', 'strong' and 'rich', with the implication that bad ethnography is 'thin', 'weak' and 'poor' – or simply absent. Before the conferences then professionals are already well-rehearsed in certain criteria that allow them to evaluate research; we saw in Chapter 4 that, through their education and training, they have already learned to discriminate in general terms between 'good evidence' and 'bad evidence', and so on. In addition, the professional conference itself often recapitulates a history of its discipline by means of which practitioners are supposed to acknowledge its embarrassing failures and simultaneously take due notice of their profession's perceived accomplishments: what now counts as 'good research' and marks

out a 'good' practitioner. Such skills are often tacitly acquired and then translated into a moral language through which the tenets of evidence-based research seem ever more definitive. In the meantime, the assumptions built into this scientific epistemology and its notion of 'evidence' are left largely unquestioned.

The conference is thus a space in which attendees consume, and appropriate for their practice, scientific evidence. It is also a space in which the self-definition of a community of practitioners is put to work. It is through roundtable debates, presentations, question-and-answer sessions, conversations in the corridors, networking during lunchbreaks, and in activities beyond the conference venue itself – the gossip and discussions in the pub, for example – that professional identities and values are wrought. This is not an easy and acquiescent activity, nor is it meant to be: dissent and debate are sought and self-consciously practised as part of what it means to participate.

During my fieldwork, the professional conferences undoubtedly offered a battleground where seeming life-and-death issues were sometimes fought, but it was also through such battles that consensus and commonalities were then forged and confirmed. I saw how professionals in moments of heated debate were also ready to agree on a common purpose. 'We are here because of research after all' was a typical assertion that brought disagreements to an end. On one such occasion, one presenter had had enough of a roundtable debate when he resolutely declared: 'let the evidence speak for itself!'. The problem was, of course, that evidence does not speak for itself. It needs speakers and, more importantly, an audience.

In the conferences I attended, the presentation of evidence-based research was usually taken to be a scenario in which presenters 'inform' an audience, as if the research was intrinsically self-evident. In an early exposition of the study of scientific practice, Latour wrote: 'The strength comes from the representatives' word when they do not talk by and for themselves but *in the presence of what they represent*' (1987: 72; original emphasis). Drawing on some of the insights from this earlier work of Latour (1987), we could approach the presentation of research as an act that relies on specific technologies (including visual, material, and textual) with which the presenters-as-representatives persuade their audiences of the significance of their research and its findings. The conference offers in this sense a representational stage on which research, conducted elsewhere, is enacted; the conference itself being a performative instance of a community of practitioners.

Like scientific journals, conferences have increasingly become international affairs that allow professionals to share their research beyond recognised national or institutional domains. That is, they provide another means of making research 'public'. Conference presentations are themselves occasions that re-present the particular empirical contexts in which 'evidence' was said to be produced. The extensive publication of journals, together with conferences, entail formal processes of what Shapin and Schaffer (1989) refer to as 'witnessing'. In bringing professionals together, conferences gather witnesses – who must be persuaded by the scientificity of research and the 'fact' (such as a new intervention) that it claims to represent. This involves performative occasions of re-presenting which enable the evidence to appear 'to speak for itself'. Many such occasions draw their authority from claims to objectivity and rational scientific process, enacted through the *aesthetic* demonstration of visual models that pertain to be absent of particular 'political' or 'subjective' intention (Bruun & Pearson 2018), although they are often crucially central to decision-making and policymaking on an array of issues. Scientific persuasions of this kind usually rely on visual-linguistic representations – such as diagrams, statistics, maps, and other two-dimensional models (see Coopmans et al.eds 2014) – displayed, as they often are in conferences, in PowerPoint presentations, for example, and projected on a whiteboard or screen.

For scientific research to become a robust 'fact' it needs to be witnessed beyond the context (e.g. research clinic) that produced it (Latour 1987). The process of 'witnessing' here is most obviously pursued through the widespread practice of publication in which research takes a textual form, whether in these conferences or in peer-reviewed journals thereby respected for their scientific and academic credibility. Journals are published in print and online, accessed and read; they are distributed and circulated amongst teachers, colleagues, students, enemies and friends, crossing national and institutional borders within minutes. The more witnesses, the better. As academics often tell each other: 'publish or perish' – a maxim apposite to the discipline of psychology. In the professional conferences of evidence-based therapy, the publication of research seems like a race, with five-year-old research publications considered more or less out-of-date. 'Science moves fast', I was told.

The general analytical point to highlight here is fairly straightforward: conferences, alongside scientific journals, qualify – in other words, they equip, instantiate, factualise – research. If not its facticity per se (the research produced as 'fact', in the manner described by Latour and Woolgar [1986]), then at least its actuality: the fact that the research happened; the

trial was conducted, the data exist, the evidence can be witnessed with your own eyes. It could be said to be a central feature of conferences that they bring together empirical contexts beyond themselves. They are performative in an important sense; they are also 'meetings' of a kind (Brown et al. 2017). Conferences – together with the universities, clinics and organisations that shape them, including the governing and regulatory practices implicated in this complex of institutions – have all played their part in defining and shaping a science of psychotherapy.

'A real science'

Rejecting psychoanalysis

In the conferences, psychology was presented as a thoroughly scientific discipline and CBT was generally cast as the ideal of a psychological intervention science. Indeed, 'evidence-based psychological therapy' appeared synonymous throughout with some form of CBT. This conviction was often established in opposition to other psychotherapies deemed 'pseudo-scientific', based on 'anecdotal' accounts or otherwise lacking in scientific evidence of effectiveness.[87] 'Psychoanalysis' (or any other purportedly outdated form of psychotherapy) was often the target of such opposition against which CBT upheld its scientific credibility.

People attending these conferences expected to engage with 'real science'. A particular language of psychology was put to work – 'trials', 'experiments', 'data', 'statistics', 'diagrams', 'interventions', and 'measures' – which most practitioners had already acquired through their education and training. This was all felt to be 'real science'-talk. However, in these conferences and outside of them, an older language of psychology had provided the definitional backdrop against which the language of a 'real science' was pursued.

Any reference to 'dreams', 'symbols', 'the Oedipus complex', or any other obvious psychoanalytic artefact would be out of the ordinary. None of the CBT therapists I met spoke this language.[88] Rather, disconnection from older psychotherapeutic schools deemed 'pseudo-

[87] A reported lack of 'evidence-based' research in psychotherapeutic fields other than CBT has often been taken as sufficient proof in and of itself of their 'ineffectiveness' (Chambless & Ollendick 2001). However, many psychotherapeutic disciplines (e.g. child psychotherapy, music therapy, and other art psychotherapies) have been latecomers to the research practices derived from EBM and some have been explicitly averse to its scientific convention (Berg & Slaattelid 2017; Marzillier 2004).

[88] The exclusion of a psychoanalytic language may be surprising to some anthropological readers, as psychotherapists and psychologists are still frequently characterised as Freudians of some sort in anthropological texts and lecture rooms. Whilst varying degrees of engagement between psychoanalysis and certain strands of anthropology has continued (particularly in American cultural anthropology, see e.g.

scientific' was actively sought and confirmed in many instances of the conferences and beyond. When presenters or other participants occasionally referred to Freud – or another such figure or concept apparently deprived of scientific credibility – eyebrows were raised in objection and eyes glazed over. 'Here we go again', whispered one attendee to me as we listened to a presenter giving a paper on the treatment of trauma, 'can't we just stick to the facts? Freud and his followers are dead and long gone.' I soon learned that any mention of 'the psyche' evoked the threatening category of 'pseudo-science' and raised eyebrows and tuts of disapproval could be expected. Attending professional conferences reminded practitioners to think like scientists and to be 'scientific'.

On one such occasion, at the final 'drinks reception' of a five-day annual conference on CBT, I was engaged in a conversation with a team of researchers and therapists from a British university, when a young CBT therapist asked me how I had found the whole conference, knowing that I was an anthropologist doing research on psychological therapy. I wondered aloud, rather unreservedly, that I was surprised how none of the workshops and presentations had engaged or even mentioned psychoanalysis or psychodynamic psychotherapy – from what I had learned about CBT in this conference at least, it seemed to me that CBT had some important features in common with earlier schools of psychotherapy.[89] 'Well, what did you expect?', came the swift reply from the younger practitioner, 'this is a conference on CBT – not psychoanalysis.' 'CBT is based on science, psychoanalysis is not,' added another.

Such explicit comments were common as one regular practice of placing 'evidence-based psychological therapy' or 'CBT' into the 'science' category. 'Psychoanalysis' and even 'Freud' himself quickly became all that present-day psychotherapy was not. Psychoanalysts, and other such practitioners, were 'old-fashioned' and out of touch with the practical realities of their patients. They were deemed irresponsible for apparently allowing psychotherapeutic treatment to be a lengthy, time-wasting (and consequently costly) affair. CBT practitioners quietly described psychoanalysts or psychodynamic psychotherapists as 'stuck in the past' or obsessed with 'the unconscious'. Both the psychoanalytic 'past' and 'unconscious' lacked scientific credibility. Psychoanalysis and its various descendants were considered unscientific not least

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LeVine 2010; Luhrmann 1998; Schwartz et al. 1992), it would be a mistake to assume this kind of continuity between psychoanalysis and other psychotherapies.

[89] With this and other such references to psychoanalysis and psychodynamic psychotherapy, I do not mean to imply a special endorsement or sympathy reserved for these practices as opposed to CBT (I have examined a branch of psychoanalytic therapy elsewhere, see Bruun 2014a).

because many of the key ideas ascribed to them were deemed untestable: 'How would you even put the "unconscious" through a clinical trial?', remarked one psychologist, laughing.

CBT, on the contrary, was presented as dealing with 'the present' and 'the conscious mind'. And in a similar opposition to older psychotherapeutic schools, CBT was celebrated for 'solving problems' rather than 'dwelling' on them indefinitely. These professionals, self-consciously scientific and with a firm grasp on 'evidence', had therefore long thrown out the 'psyche'; they were instead dealing with well-established scientific objects such as 'cognition' or 'the brain'. Indeed, Freud seemed dead and long gone in these conference halls, and 'the psyche' with him.

From 'pseudoscience' to 'real science'

Psychotherapy has long struggled to achieve scientific credibility on an equal footing with a biomedically-orientated psychiatry in the provision of mental healthcare in the UK, but British psychotherapies have not been alone in this struggle; similar epistemological battles have been fought elsewhere in Europe and North America. During the twentieth century, this seeming rivalry was important in the historiography of both fields where it has travelled under rallying cries such as 'talk therapy' versus 'drug therapy'. More recently, the historiographical juxtaposition of psychotherapy and psychopharmacology has reappeared as a perceived dispute between 'the mind' and 'the brain'. These are debates and conflicts that still seem to be dancing around a question of whether the remedy for 'mental illness' is to be found in the person or in the pill: 'is it me or my brain?' (Dumit 2003). Since at least the 1970s, the use of psychopharmaceuticals has been the steady hallmark of a properly 'scientific' intervention in the treatment of people diagnosed with mental illness (Jenkins 2010).

In the early 1990s, it was declared that we were finally, and securely, in the 'Decade of the Brain', as the US National Institute of Mental Health asserted (Danziger 2008). Emergent research in cognitive neuroscience, neuropsychiatry and neuropsychopharmacology promised to pave the way for truly objective, scientific explanations of what it means to be human (Rose & Abi-Rached 2013), not least in the area of mental healthcare. 'Real science', as a majority of psychiatrists and scientists proclaimed, had finally defeated the 'pseudoscience' of psychotherapy (cf. Lilienfeld et al. 2004): mental health problems were firmly located in the neurological make-up of 'the brain'. They were 'brain disorders' that would eventually yield to drugs (Luhrmann 2012).

The product of a biomedically-orientated psychiatry, psychopharmacology (now increasingly known also as 'neuro'-psychopharmacology) remains the most prevalent form of treatment in contemporary mental healthcare in the UK. We have already seen in Chapter 2 how psychotherapeutic and psychiatric treatments have jostled for scientific credibility in different ways during the twentieth century. We also saw how 'evidence-based' practice has become instructive of how we should understand psychological healthcare, namely that psychological therapies are based on scientific research; they are the product of an 'intervention science' (cf. David et al. 2018), not a healing art.

The scientist-practitioner

Most IAPT practitioners who attend conferences are already experienced psychotherapists. They have already learned to work therapeutically, and part of this means understanding scientific research as informing clinical practice: how to determine the most effective psychological treatment for a specific condition.

Conferences are meetings in which practitioners openly talk about how to 'apply' evidence-based treatments, how to recognise 'good' from 'bad' practice in doing so – with plenty of conference papers dealing with the pedagogical aspects of all this. 'Applying' evidence-based research in clinical practice means working in accordance with the official protocols that have been produced by IAPT; manuals are in turn based on, and continuously updated in line with, the clinical guidelines published by NICE, the UK executive body that provides evidence-based guidance for the NHS.

The idea of 'applying' research to clinical contexts and issues is an instructive reminder here of an epistemic hierarchy amongst the professionals of the conference. Scientists and researchers are often perceived amongst their peers as the ones on top of a hierarchy of knowledge production. Scientists are considered the spokespersons of 'what we know', as conference presenters put it. The therapist is considered secondary to the scientist in this division of labour, applying the findings that the scientist produces. Therapists must thus aspire to be 'up-to-date' with scientific research. Conferences are seen as the main arena in which this transmission of knowledge occurs, but it is ultimately in the very different contexts outside the conference room that 'evidence' is put into practice.

This role of the therapist is discussed with reference to the epistemic ideal of 'the scientist-practitioner'. Since scientists and researchers who attend these professional conferences are

understood to provide the findings of scientific research which clinicians are then understood to apply in their clinical practice, thus making psychotherapy 'evidence-based'. Consequently, the very notion of applying research to clinical work also means that therapists are the ones entrusted with an authority of judgement (which is seen to derive from their clinical experience) in qualifying the relevance or suitability of any given research and its claims. A specific treatment might be deemed successful in the clinical trial, but the same treatment might not always work well outside of the particular empirical context that demonstrated its 'effectiveness'. Practitioners-as-scientists usually conduct research through their academic affiliation with universities or university hospitals and clinics, in specialised research centres and clinical labs. Research findings are then disseminated through these professional conferences and peer-reviewed membership journals as well as other international science journals. This extensive network of researchers, clinics, labs, hospitals and university research units is part and parcel of the ongoing production of a psychological science from the clinical trial of an intervention to the clinical consultation in which the tried and tested intervention is put into practice.

The epistemic ideal at work here – of clinical practice as the application of scientific evidence – now regularly moves hundreds of practitioners many miles into conferences. It is an ideal that came into being with the rising critiques of clinical judgement in the 1970s and has also meant that the objectivity of clinical psychology now also distinguishes itself from older notions of scientific objectivity that emerged in the nineteenth and early twentieth centuries.

The invention and reinventions of objectivity

What are the different kinds of objectivity and how have they been given new life in evidence-based psychotherapy? Daston and Galison's (2007) historical research presents an extensive account of scientific objectivity which traces its multiple and varied inventions across several emergent disciplines pertaining to the 'the Arts' and 'Sciences' – including this division itself – during the eighteenth and nineteenth centuries in particular. Importantly, Daston and Galison's work shows how the concepts of 'objectivity' and 'subjectivity' came into being in contradistinction to one another. 'Subjectivity' was all of that 'objectivity' was not: the 'individual mentality' and the 'inner life' of a person with all its perceived idiosyncrasies such as emotions, dispositions and desires – all of which was deemed to get in the way in the laboratory and corrupt a truly 'objective' observation and representation of any 'phenomena'

out there in an already given 'natural' or 'external world'. This bifurcation came through a self-defining community of scientists and shaped 'science' and 'the scientific' (including 'the scientist') into what Daston and Galison (2007) describe as 'ethico-epistemological' activities or epistemic virtues. The most prominent of these epistemic virtues was the ideal of the scientist as detached observer.

Daston and Galison outline four main modes of epistemic virtue that emerged over the course of at least the seventeenth century up to the middle of twentieth century. The first of these four ideals they call 'truth-to-nature' which became prominent in the early eighteenth century. It was explicated in great detail by the so-called 'Enlightenment naturalists', such as Johann Wolfgang von Goethe (1749–1832). It was practised particularly in the fields of cartography and physiology and their preoccupation with atlas-making and depictions of 'the natural world', primarily plants and animals. The aim was to produce, usually through drawing, idealised representations of natural objects; 'a reasoned image' of specimens excluding from it 'individual' and 'atypical' characteristics in order to depict the essence or truth of God's creation as reasoned by the naturalist.

However, the naturalist's capacity to represent a 'natural phenomenon' in its truthful form, guided by his reason to distinguish the essential from the anomalous, was an endeavour that was increasingly called into question in the first half of the nineteenth century. The 'subjective' disposition of the image maker was problematised: the truthfulness and authenticity of the image was thought to be prone to contamination by the naturalist's subjective preconceptions of the object in question. A new scientific ideal emerged which sought instead to represent 'Nature' without any intervention on the part of the image maker. It was during this same period that the term 'scientist' apparently came into being, said to be first coined in 1833 by William Whewell (1794–1866).[90] In an age of factory production, the scientist as a detached observer was now expected to strive to work like a disinterested machine capable of producing accurate representations of objects without the interference of his own 'subjective' participation: the scientist had, on the contrary, to be 'objective'. The new epistemological activity that arose in the mid nineteenth century was to produce visual images through mechanical depiction. This 'mechanical objectivity' came to the fore with the invention of machines and then photography and other visual technologies during this period. Objectivity

[90] 'Natural philosophers' and 'natural historians' were common terms in the eighteenth century up until the label 'scientist' was introduced and then widely employed post-1830s (Shapin & Schaffer 1985).

meant non-intervention and detachment on the part of the scientist, allowing nature to 'speak for itself'.

The third epistemic virtue outlined by Daston and Galison was in many ways an intensified version of mechanical objectivity. By the end of the nineteenth century, for some scientists, even photographic and mechanically produced images were not objective enough. They sought instead to arrive at formal structures of relations between phenomena abstracted away from laboratory observation and mechanical depiction. Daston and Galison refer to this even more 'austere' form of objectivity as 'structural objectivity'. It was particularly informed by the work of mathematicians, linguists and philosophers concerned with theoretical abstractions independent from any observer (machine, human or otherwise) in their emphasis on structural relations rather than empirical 'objects'.

Finally, the fourth epistemic regime noted in this historical survey of objectivities was in many ways a response to the self-abnegating and non-interventionist modus operandi of both mechanical and structural objectivists. During the early decades of the twentieth century, the proclaimed 'objective' authority of mechanical automaticity and the elimination of the scientist-observer became progressively challenged by scientists who advocated for a strategy that explicitly acknowledged the necessity of seeing scientifically through a trained, interpretive 'eye'. Daston and Galison refer to this epistemic virtue as 'trained judgment' (2007: 309-361). The trained and skilled professional with 'seeing eyes' was increasingly regarded as a necessary supplement to the 'objective' production and assessment of scientific objects, whether these objects took the form of images, diseases, diagnoses, and so on. In medicine and psychiatry, this particular kind of epistemic ideal became known as 'clinical judgment' and 'clinical reasoning' (or 'the art of medicine') throughout the twentieth century. In an important sense, clinical judgment still involved, and involves, a 'detached' perspective on the part of the practitioner, but objectivity no longer meant working as a disinterested 'hands-off' scientist.

Anthropologists have shown how practitioners come to embody and enact this objectivity in different arenas of contemporary medical education and practice wherein particular corporeal and affective proprieties of detachment are acquired in the making, unmaking and remaking of different 'bodies' – involving living and dead bodies, cadavers and body parts, atlases, skeletons, manuals, 3D models and much more – as we move from anatomy teaching and dissection rooms to surgery and organ transplantation, and beyond (McDonald 2014, 2015; Hallam 2017; Olejaz 2017; see also Candea et al. 2015).

It is important to note that the different modes of objectivity discussed above did not succeed each other in one linear fashion nor did the predominant ideals, such as trained judgment, cancel out former epistemic virtues. Rather, Daston and Galison make the case that earlier epistemic activities largely remained as they adjusted to competing notions of objectivity. For example, certain versions of nineteenth-century 'mechanical objectivity' have in many ways retained a hallmark of scientific objectivity, whilst it could also be argued to have been revivified with the invention of new visual technologies from the 1980s onwards with the development and use of neuroscientific imaging (such as MRI scans), virtual 3D models, and other computerised images. These have undoubtedly injected scientific practices with renewed enthusiasm for visual and automated representation (Cohn 2004; McDonald 2014; see chapters in Coopmans et al. 2014; Grasseni 2009).

So, where does the objectivity of present-day evidence-based psychotherapy fit in these different (historiographical) modes of objectivity? In the following sections, I want to discuss three definitional shifts that I suggest have been fundamental in shaping psychotherapy into a persuasive object of scientific observation.[91] These shifts could be summarised briefly as discourses of 1) the objective and subjective; 2) useful science; and 3) evidence.

The 'objective' and 'subjective'

The first shift has to do with how nineteenth-century psychologists – such as Edward Titchener (1867–1927) and William James (1842-1910) and their students (see Coon 1993; Green 2010; Mandler 2011) – began to formulate a language of 'objective' and 'subjective' in a way that is evocative of present-day psychological therapy, but which differs from the definitions discussed above. What we have seen so far, drawing on the scholarship of historians of science (e.g. Daston 1978; Danziger 1997; Daston & Galison 2007), is that objectivity was all of that which subjectivity was not and vice versa. Importantly, as the two concepts emerged in a mutual definition of each other from the mid-nineteenth century onwards, 'objectivity' came to designate the pursuit of 'Science' which marked out a scientific epistemology and virtue (the scientist as detached observer first and foremost); and, at the same time, 'subjectivity' became increasingly associated with activities pertaining to 'the Arts' and the realm of human

[91] Observation refers here to the use of the randomised control trial (RCT), including clinical trials based on this experimental design.

interiority and creativity. Academic disciplines – and their institutional divisions – have largely inherited and revitalised these bifurcations and definitions.

However, there is another historical point to highlight here which is rarely discussed. (Daston and Galison's discussion of nineteenth-century psychology is after all sporadic and truncated by their focus on cartography.) Namely, psychologists in the late nineteenth and early to mid-twentieth centuries deployed the dichotomy of objective/subjective in a way that differs from the common usage of these terms that we are more familiar with today. That is, they were used in the classification of two distinct methods of scientific observation (Woodward & Ash 1982; Green 2010): 'objective' was a term used to refer to what we might call an *extrospective* observation of human (or animal) behaviour, whilst the term 'subjective' referred to an *introspective* observation of one's own 'mental processes' (or those of another human subject). In other words, 'objective' methods denoted a perceived exteriority ('behaviours' visible to the eyes of the scientist-as-observer) distinguished from 'subjective' methods which denoted an impartial introspection of a perceived cognitive interiority (such as 'the mind' or 'consciousness'). The latter method of observation itself suggested a particular epistemic stance, in the words of Daston and Galison. It was one which relied on certain skilled techniques of what became known as 'introspection, which encouraged a particular conceptual vision of the subject matter of psychology as it turned to the nature and significance of 'the mind'.

Psychologists at the time disagreed amongst themselves which of the two methods were most scientific – and whether phenomena like 'mental processes' or 'the mind' could be considered proper scientific objects (Rieber 1980; Woodward & Ash 1982; Rose 1984; Mandler 2011). Perhaps unsurprisingly, with the bloom of William Wundt's (1832–1920) 'experimental psychology' (amongst others) in Britain and the rest of Europe and a general effort to distinguish psychology from philosophy and metaphysics, this vision of psychology – the 'subjective' method – was deeply controversial and largely discredited. Wundt vehemently rejected the idea of introspection as a scientific enterprise for psychology (cf. Wundt 1902) and many psychological scientists I met consider him the founding father of the discipline for exactly those reasons. According to Wundt and others who were later grouped together under the name of 'behaviourists', the very notion of 'the mind' was nonsensical and at best obsolete: it was derided by Wundt and his colleagues, in self-conscious distinction to philosophy, as a *metaphysical* concept – and hence unscientific (Mandler 2011). As such, the mind was best left to philosophical speculation.

Other psychologists however, such as Edward Titchener (1867–1927), a former student of Wundt, argued for introspection as a scientific approach to the study of 'the human mind' in which the 'introspective psychologist' assumed the position of an impartial and disinterested 'introspector', capable of observing his own and others' thoughts from an educated position of detached reflection (see Green 2010). These earlier psychological scientists were thus interested in what some of them described as 'mental processes' that could be conceived of as scientifically feasible objects of observation for the trained scientist-as-introspector. It was in the light of this enthusiasm and the disputes it generated that Titchener proclaimed that the psychologist as 'introspector' promised a scientific 'description of the world with "man left in it"' (Titchener 1915: 8).

This proposed 'subjective' method of observation – the very idea of introspection involving a human subject required to inspect their own perceived 'mental' experience – is a matter of interest to this thesis precisely because it shows us the theoretical commitments and contestations amongst psychologists over a century ago and what some of these psychologists seem to share with their present-day colleagues. And more to the point: I would argue that these early advocates of psychological introspection preceded the scientific persuasions that were later to become the heart of evidence-based psychological therapy: the notion of the human subject as a self-inspector with a capacity to observe and self-report on their own 'mental health' or 'mind'.[92]

The human subject's assumed capacity to introspect and the purpose of introspection itself are taken up and enacted in different ways in contemporary psychological therapies, and we will see some aspects of this in Chapter 6, when we turn to the therapeutic practice of CBT and mindfulness.

Towards a useful science

The second shift has to do with the significance of 'science' and its counterpart 'society'. In an older conception of scientific objectivity, 'objective science' was ideally driven not by its potential usefulness to 'society', 'the public', or 'individuals' – as people in the UK and elsewhere might understand and live scientific facts today (e.g. Dumit 2004; Martin 2007;

[92] Mental health or mind is of course understood here, ethnographically speaking, with various reference to terms such as subjectivity, inner life, cognition, mental processes, events or experiences, and so on – concepts that are widely deployed in contemporary psychology *and* in social anthropology (see Introduction).

Strathern 2005) – but by a *disinterested* observation of the world (Green 2010). Scientific objectivity was, in other words, to be guided by the ideal of what some scientists of the nineteenth century would call a 'useless' science (ibid). Science, in the most common version of this view, should not be made to serve or be dictated by presumed societal needs because such an enterprise was believed to obscure the objectivity of scientific inquiry. Therefore, objective science had to be occupied not with its applicability, but with an impartial account of the scientific object in question. Scientific research was seen as the neutral pursuit of objective accounts of 'the natural world'; all of which could be jeopardised if ideas of 'usefulness' had dictated it. This particular conception of 'Science' as self-consciously divested of its potential usefulness stands in stark contrast to prevalent ideas of objectivity in contemporary clinical psychology. Indeed, IAPT professionals see themselves engaged in what we might call a 'useful' science: namely, scientific research which produces *evidence of effectiveness* for societal purposes, such as interventions to be used to treat people with mental ill-health. We are also familiar in anthropology with the widespread and longstanding 'Science and Society' debates (see e.g. Edwards et al. 2007; Nowotny et al. 2001; Candea 2016), which are very much part of this latter conception of science prevalent in contemporary clinical psychology. This shift also means that many IAPT professionals – CBT and mindfulness therapists alike – now tend to understand and discuss their work as an 'applied' science.

Consequently, I shall argue that as psychology and its practitioners have moved into an era of accountability and audit in the UK (Strathern 2000) and onto the quest for therapeutic certainty encouraged by EBM (Lambert et al. 2006), an older world of positivism in which scientists sought, and still seek, representations of 'nature' or any 'natural fact' (McDonald 2012a) has shifted into a radically more instrumentalist world with a focus on 'evidence'.

This is still a world, however, which invokes an older understanding of evidence as *facts about the world*, with the assumption that scientific facts are progressively verified or falsified in light of 'the evidence' (Goldenberg 2006). In this world, only claims verifiable through empirical observation (i.e., experimentation) are meaningful (i.e., real). In other words, the 'evidence' generated by trials is assumed to be facts about the world, about the world of mental healthcare here specifically. What I observed in the professional conferences and in meetings with commissioners, therapists and scientists was that this specific approach to evidence-making is what warrants the qualifying words of 'scientific' research and 'objective' science. However, unlike the logical positivists of the early twentieth century, these professionals

engaged in evidence-based research do not pose 'Science' as some abstracted logical system of explanation. Rather, I would argue that scientific research is now firmly understood in terms of its instrumentality. Scientists engaged in research into psychological therapies are explicit on this point: scientific research is about generating evidence that has a specific use and purpose in therapeutic contexts. They talk about it in largely functional terms: evidence of the effectiveness of an intervention.

An evidential objectivity

The third and final shift I want to discuss concerns the significance of evidence alluded to above. A much-cited definition of EBM describes the movement as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (Sacket et al. 1996: 71). As an initial observation, we might note that the ubiquity of this kind of reasoning in evidence-based practice and its seeming obviousness in the therapeutic world make it difficult to argue against without appearing to also argue against 'good, effective care' or against the idea that practitioners should be able to be held accountable for their clinical decisions. Similar tensions emerge in other logics of care (cf. Mol 2008).

In the contexts of conferences and in conversations with IAPT professionals, the qualifying 'objective' was deployed to describe the successful production of 'evidence' on which therapies were seen to be 'based'. 'Evidence', in turn, was specifically understood as evidence of effectiveness, with effectiveness being a marker of (therapeutic) usefulness. Evidence-based therapy is thus about 'what works', as both scientists and therapists would often point out. It hinges on questions and concerns that we might think of as instrumentalist: the testing of a means to pursue an end, with the means and the end result referring respectively to the 'test therapy' and 'patient recovery'. It is consequently orientated towards already defined and classified therapeutic problems. The scientists would often describe their experimental research to me as 'problem-solving' and 'goal-oriented' – a language evocative of CBT itself.

Hence the instrumentalism at work here is apparent in the way in which practitioners and scientists alike talk about objectivity in largely methodological terms: as the testing of interventions in order to determine the reliability of these to serve a clinical purpose effectively. All of this appeared to be in line with the tenets of EBM that philosophers, anthropologists and sociologists have identified (see e.g. Goldenberg 2006; Lambert et al. 2006; Timmermans & Berg 2003b). The objectivity of psychotherapy could thus be said to lie in the achievement of

its *evidentiality*. It could be said to differ, therefore, in important respects from other prevalent types of objectivity identified by Dalston and Galison (2007) as I discussed above – although it does not necessarily negate them. I would also situate this kind of *evidential* objectivity as one amongst a variety of contemporary epistemic practices involved in the 'collective management of evidence' to which *regulatory* objectivity refers (cf. Cambrosio 2006, 2009).

The methodology of the randomised control trial (RCT) is the defining feature of this type of scientific objectivity, analogous perhaps to how the camera and ocular machines defined mechanical objectivity in the nineteenth century (Daston and Galison 2007). But unlike the mechanical and structural objectivists, present-day psychological scientists engaged in psychotherapy research do not see themselves as detecting a universal nature or structure of the object of experimentation. Nor is their work primarily directed towards producing or enacting visual representations of their scientific objects ('interventions'), as we might observe in other contexts of biomedicine wherein brain scans, anatomical atlases, 3D models of the human body, and so on, come to hold a definitional or ontological epistemic authority (see e.g. Cohn 2004; Hallam 2013; McDonald 2014; Mol 2002). In making this point, however, I should likewise stress that strong representationalist and universalist ambitions still inform the scientific epistemology of psychotherapy research. Although researchers might not, in their own terms, be engaged in the discovery of some absolute truth or the generation of visual representations, many do see themselves nonetheless as revealing some generalised if not universal understanding of phenomena discussed as human psychology, mental processes, cognitive structures, and so forth. In the professional conferences I attended, it was also not uncommon for psychological therapies to be presented in such a way as to suggest that we were witnessing interventions that could ideally be applied anywhere in the world.[93]

Above all though, researchers seek to ascertain the effectiveness and applicability of a tool for a task: 'what works?', was the common question everywhere. Evidence-based research is understood then as providing a basis for *effective* psychological therapies and doing so partly in an attempt to establish the scientific validity of psychological healthcare in general. This has been an important achievement for the professional communities of psychologists and CBT

[93] Anthropologists have countered such universalist ambitions within the psy disciplines in rather different ways, from ideas of cultural variability (e.g. Kleinman 1980; Littlewood 2002; Luhrmann et al. 2015) to radical re-thinkings of the relationship between anthropology and psychology (Toren 2012).

therapists in their self-definition as practitioners of 'real science' against the perceived underbelly of 'pseudoscience'[94] still felt to haunt the discipline of psychology.

Pills and the problem of psychotherapy

After several years of training and clinical practice, psychotherapists seem generally to end up feeling confident about the effectiveness of the treatments they provide, despite the apparent difficulties of knowing how and when a treatment was deemed 'effective'. The epistemological uncertainty involved here is a lingering ambiguity concerning the testing of the effectiveness of a psychological therapy in clinical trials.

Psychotherapy still appears far removed from the testing of interventions such as medication: psychotherapeutic care appears to be nothing like prescribing or taking medication. This might seem like an obvious and otherwise innocent point, but it is partly through the metaphorical 'pill' that psychotherapy has eluded its own ambiguity and complexity. In its quest for an 'evidence-based' status, psychotherapy is required to make itself amenable to the scientific parameters of EBM. This requirement has proved challenging, however, and there has been a flurry of publication activity concerning this.[95] One main challenge has been that EBM proposes a strict methodology for demonstrating evidentiality primarily through the use of RCTs in the assessment and evaluation of interventions.

For any intervention to be trialled and tested within the parameters of the RCT it must be treated as if it were a singular, homogenous thing. The object of experimentation must be held still, it must be stabilised or 'controlled' (Latour & Woolgar 1986; Shapin & Schaffer 1985). Ambiguity and complexity are therefore eclipsed where singularity or certainty is sought. The RCT is designed to determine the causal relationship between single variables: for example, and to put it simply, the causal relationship between a) a chemical compound (e.g. pharmaceutical drug) and b) physiological or neurological reactions. This causal relationship is tested in a controlled clinical setting based on a randomisation process. RCTs entail an epistemological commitment to what we might term empirical reduction (Berg & Slaattelid 2017) in which 'psychotherapy' as a practice (or set of practices) is treated as if it were a stable entity. The

[94] For some ongoing debates on the scientific psychology literature, see e.g. Lilienfeld (2010); Lilienfeld et al. (2004).

[95] See e.g. Parry (2000); Chambless & Ollendick (2001); Bower & King (2000); American Psychological Association (2006); Berg & Slaattelid (2017); Greenhalgh et al. (2014).

research methodology of an RCT necessitates a conceptualisation of psychotherapy as a 'single variable' – the metaphorical 'test drug' – that can be 'controlled' in the trial. This requires practices of standardisation and exclusion. During the clinical trial, practitioners are required to follow strict clinical protocols in delivering an intervention, excluding from the practice of psychotherapy ('the intervention') the practitioners themselves. Protocols are not merely guidelines, they are prescriptive: they impose specific rules for the conduct of the therapeutic session (the experimental setting) and stipulate an exact procedure for the provision of the intervention that is the object of the trial. The protocol is thus part of the practices of standardisation and stabilisation.[96] These ideas are also found in definitions of CBT itself when it is conceived of as a 'set of techniques' in which effectiveness and applicability are inherent to the intervention itself rather than dependent on the circumstances (such as the relationship between the therapist and the patient) in which the intervention is carried out.

Historically, RCTs were also designed in the testing of pharmaceuticals (Bothwell et al. 2016; Lambert 2006; Timmermans & Berg 2003). The modern RCT is said to have been developed in the mid-twentieth century by medical researchers concerned with the treatment of 'diseases' and in the assessment of new medications, especially the use of antibiotics, antihypertensives and antipsychotics (Bothwell et al. 2016). RCTs quickly became convention in pharmaceutical research during the second half of the twentieth century, but researchers initially struggled to establish RCTs as a conventional research methodology in the area of psychotherapy (Bower & King 2000). Even well into the 1990s, and although some psychiatric researchers had conducted many RCTs of psychotherapy by this time (Bothwell et al. 2016), clinical researchers more generally still struggled to apply RCTs to research in clinical psychology and some deemed it an 'impossible' evaluation of psychotherapy: it was argued, for instance, that psychotherapy was highly 'individualized', resembling nothing like the testing of psychotropic medication (Seligman 1995). A renewed enthusiasm for cognitive and behavioural therapies came to the rescue (cf. Salkovskis 2002; Layard et al. 2007; Butler et al. 2006): these psychological therapies promised, unlike their psychodynamic predecessors, a short-term and efficient approach to mental healthcare. They were soon gathered collectively under the acronym of 'CBT' (Marks 2012). In the UK, CBT became the most invested-in research topic in clinical psychology – pioneered by research units at Oxford University and Kings College

[96] Latour and Woolgar (1986) have described some aspects of this process as the practice of 'purification'.

London, followed by Cambridge and Exeter Universities (Marks 2012, 2015). CBT research eventually paved the way for making RCTs a gold standard of psychotherapy research more broadly such as mindfulness.

Whilst the movement of EBM has clearly expanded beyond the testing of medication, both the experimental model of the test drug and the biomedical model of intervention still largely served as epistemological referents in 'evidence-based' research as presented and discussed in the psychology conferences I attended.

And yet psychotherapy is not a pill. It is not a chemical compound nor a psychoactive substance; it is not a medication to be swallowed or injected. 'Drug therapy' and 'talk therapy' differ in their objects, assumptions and practice. This point raises at least two basic questions: what exactly is psychotherapy and how might it differ from medication? These are questions of ethnographic import. Researchers and practitioners of evidence-based psychotherapy have generally sidestepped such problems of ontological implication: are pills and psychotherapy the same 'thing'? What constitutes the nature of psychotherapy? And so on.

They have instead framed evidence-based research in psychology as a matter of methodology: psychopharmaceuticals and psychotherapies should be tested by the same standards.[97] Of course, this was partly owed to a general insistence on what commentators have seen as scientism within EBM (see Goldenberg 2006), and it remains persuasive: if medical interventions have to undergo clinical trials as a validation of effectiveness (and in order to be implemented in a healthcare service), then surely psychological therapies should be subjected to the same evaluation? In the meantime, this extensive focus on methods of testing seems to have muted in discussions, in conferences or journals, the important question of what exactly is being tested. It is now generally felt, nevertheless, that applying the framework of RCT to psychotherapy research makes 'talk therapy' and 'drug therapy' compatible objects of scientific evaluation. Brought together by the trial, differences have seemingly been reconciled.

In the discussions and debates on this topic, issues have thus been frequently addressed as inherently 'methodological'. That is, research on psychotherapy tends to be a question of designing or adjusting the precise conditions and technologies of trials. However, the experimental model itself (evaluating psychotherapy through the RCT) often eludes critical questioning, as researchers' attention is turned to a concern with the accurate conduct of the

[97] I use the term methodology here to refer to the systematic *description* and *prescription* of a set of methods.

scientific method: which statistical standards should be used? Which measures are most reliable? How should scales be evaluated? What is the minimum number of research subjects (patients) for a clinical trial? Should all patient groups be evaluated against the same measures? And so on. These questions came up regularly in the conferences and they are questions that challenge the protocols and conventions of carrying out experimental research. They are not, however, meant to challenge the scientific epistemology on which evidence-based psychotherapy rests – such an undertaking could easily appear to be hostility towards scientific authority, or simply science-bashing. Yet the challenges that researchers often report when discussing the design, conduct and dissemination of RCT research could be seen as inevitably epistemological questions. That is, methodological debates end up pointing to the many different ways in which researchers acquire knowledge, the empirical validity of methods used to acquire knowledge, and theories of knowledge involved ('How do we know what we know?').

The problem of making psychotherapy amenable to the experimental methodology of EBM has been duly noted by practitioners of psychotherapy themselves and several solutions to overcome this problem have been proposed but remain contentious. Practitioners have frequently discussed such matters in meetings and conferences and in the pages of scientific journals.[98] They are discussed, in other words, in the arenas of witnessing important to the construction of these issues as common matters of concern that might ultimately divest themselves of their own contexts of construction; we could use insights from elsewhere here to suggest that such issues centre around how to turn aspects of therapeutic interventions not into matters of concern but into matters of fact (Latour 2004b; Shapin & Schaffer 1985).

The contours of scientificity that appear in the technologies of meetings and on the printed page, in the conferences and journals in this field, have generally tended to mute any radical critique. We have seen how mental health professionals who might publicly object to the premises of evidence-based psychological therapy run the risk of being subsumed under the counter-category of 'pseudoscience' and aligned derisively with the likes of Freud. When, for example, a psychotherapist in the audience at a conference on IAPT openly questioned the validity of 'evidence-based' approaches based on RCTs, the presenter responded with moral disapproval that bordered on derision: 'Most of you critics are old, bitter psychotherapists bemoaning an outdated discipline'. The criticism levelled at the approaches and standards

[98] See, for a small selection, Berg & Slaattelid 2017; Bower & King 2000; Chambless & Ollendick 2001; David et al. 2018; Greenhalgh et al. 2014; Marzillier 2004.

drawn from EBM has often been framed in this way – as the voice of an older generation of psychotherapists and psychoanalysts feeling challenged by the 'progress of science', as another conference presenter put it to his approving audience.

Proponents of evidence-based therapy seem to have been generally keen to comment that objections to EBM come from psychotherapists belonging to older psychoanalytic and psychodynamic schools; practitioners who currently stand, it is argued, to lose scientific and professional credibility because CBT and other IAPT therapies have proved themselves more 'effective'. Whilst it is certainly the case that a majority of critics of IAPT are defending older psychotherapeutic schools.[99] There is however a growing number of academic articles written by trained IAPT professionals and CBT therapists, as well as clinical psychologists and some psychiatrists, who have raised similar critical concerns about evidence-based practice from within their own professional commitments (see e.g. Binnie 2015; Chambless & Ollendick 2001; Pearce et al. 2015). Some critics question whether the evidence-based approach is the only viable method in which clinical practice can be scientifically informed and evaluated. During my fieldwork, in the margins of conferences and elsewhere, I met critics who said they sought to discredit the framework of EBM; others proposed to enlarge the notion of 'evidence' and suggested that RCTs might not always be the best research design for judging the effectiveness of psychotherapy.

The varying positions and the nuances in these debates are important to emphasise; the anthropological outsider should not too easily subsume these disputes under two enduring and neatly opposing camps – with CBT practitioners and scientists, on the one hand, and the rest (e.g. psychoanalytic psychotherapists), on the other. It seems that practitioners of CBT and other IAPT therapies, as well as those who practise psychotherapies outside of the convention of EBM, might well support or condemn aspects of evidence-based practice. It is simultaneously the case that IAPT therapists have been formally trained in evidence-based practice and tend therefore to be more committed to its protocols. Otherwise, the variety of critical stances seems in part to be owed to the broad range of psychotherapeutic training programmes and institutes in England (see Davies 2009). It is also common now for practitioners to be educated in, and work across, more than one psychotherapeutic discipline. I met CBT and IAPT therapists who had also trained as psychoanalysts, existential

[99] For a sample of such critics, see Rizq (2012); Marzillier (2004); Samuels & Veale (2009); Lees (2016).

psychotherapists, or in some other psychotherapeutic discipline commonly regarded in professional contradistinction to CBT. We should therefore not assume that we are dealing with two or more clearly separated camps of practitioners, even if the whole gamut of debates tends to be construed as such.

All of this takes us back to the general point about ethnographic definition and self-definition with which I began this chapter: we see that therapists are well-rehearsed in a moral discourse of professional self-definition, in which the apprehension of stark boundaries between therapeutic schools and related us/them distinctions are re-drawn constantly in conversations between psychotherapists and in written histories of psychology, too (for a recent example of this, see Hall et al. 2015).[100] This can seem at times to result in a never-ending ramification of sub- and counter-disciplines, with divisions wrought in self-conscious opposition and new therapeutic schools born every other year. All of this can also be brought together with seeming ease (which was the case in the NHS conferences I attended) under a single, common title of 'psychotherapy' or 'psychological therapy'.[101]

I have suggested that evidence-based psychotherapy has been effected in part by construing any tensions between psychotherapy and the RCT as exclusively a matter of 'methodology'. This shift towards a methodological framing is one owed to EBM and its prescription, ordering and regulation of scientific evidence (Cambrosio et al. 2006, 2009). We have seen thus far that the notion of evidence-based psychotherapy relies then on a redefinitional process in which 'psychotherapy' is construed as an object that can be tried and tested through randomised control trials. There are at least three practices here that have been fundamental in making psychotherapy evidence-based within this framework: 1) objectification; 2) standardisation; and 3) quantification. These are interrelated practices and are mutually implicated in the constitution of evidence-based psychotherapy. Objectification refers here to the therapeutic provision and effects of psychotherapy framed as 'objects' that can be experimented upon; standardisation concerns psychotherapy practised as a set of manualised and precoordinated 'techniques' and 'interventions'; quantification refers to the way in which a person's experience of the effects of psychotherapy is rendered into a measurable, numerical form – a number or set of numbers – elicited through patient questionnaires (also referred to as 'measures' and

[100] For an anthropological account of certain aspects of this boundary-making in psychotherapeutic training.
[101] See Introduction for comments on this terminology.

'scales'). We could say that self-reporting enacted through the use of the patient questionnaire is the central technology through which 'subjectivity' is measured and stabilised by rendering the clinical subject's 'subjective' experience quantifiable. It is also the important instance in which the 'effectiveness' of the psychotherapeutic intervention is reified 'objectively' as it quite literally appears as a score on a sheet of paper.

As a result, in the assessment of the effects of a specific psychological therapy for a specific condition, 'subjectivity' – in the sense of a putative interiority of a human subject, we might say – can seem, ethnographically, to pose problems in that the clinical subject's experience of mental ill-health and their experience of engaging in psychotherapy are neither easily nor reliably objectifiable nor quantifiable. Consequently, the main challenge has been, and continuous to be, one of inspecting subjectivity *objectively*.

This has been achieved not through a bracketing off or draining away of the 'subjective' – as we saw earlier in Daston and Galison's historiography of objectivity, and, as anthropologists might witness in other clinical contexts of biomedicine referenced throughout this chapter – but rather by transforming 'subjectivity' itself into an object of scientific observation. This is done in the daily practices of diagnosis and treatment, such as in assessment calls on the telephone with IAPT's Psychological Wellbeing Practitioners and in the therapeutic consultations with IAPT therapists. The tasks of assessment and treatment evaluation rely primarily on the use of scaled questionnaires. These provide the material means of systematic classification in which what becomes the experiential reality of the patient is ordered and scored. This procedure requires most importantly a capacity of the patient to self-evaluate and self-report, a topic we explore further in Chapter 6. The patient questionnaires both assume and require such a capacity. They are usually filled in as part of an initial diagnostic assessment, and subsequently, when used to evaluate the progress of a treatment, completed by the patient before and after consultations and therapy sessions.

The use of scaled questionnaires in psychology is of course not new and has long featured as one of the most widely used technologies in observing and evaluating subjective experience objectively. We could think of the questionnaire as a material instantiation of a simultaneous process of objectifying, standardising and quantifying. That is, in the assessment of both psychotherapy and psychotherapeutic subjects, questionnaires render apparently subjective experiences observable, measurable and numerical. Experience, we might say, becomes a score,

a quantity. As we have seen, this reconstitution has historically been a difficult accomplishment.

Appealing to 'the evidence' as a fundamental principle of healthcare seems now to be the dominant rationale. However, evidence is not about 'the world out there', as I have shown, revealing nature in its universal forms and functions. It concerns instead the certainty of effectiveness. Evidence-based practice claims to rationalise the contexts and specificities of providing healthcare, which involves framing clinical decision-making as separate from its practical complexity and ambiguity. It is precisely in this move that we see what might aptly be described as efforts to eradicate the 'social', 'political', 'cultural', and other perceived opposites of an impartial, value-free science which claims an objective grasp on reality. This has been, and is, an important achievement in establishing therapeutic certainty and in the attempt to demonstrate universal singularity in the face of what may feel like alarming complexity and multiplicity (McDonald 2011, 2017). This objectivity can cause serious troubles, nevertheless, and the 'social', 'political', 'cultural' and other 'factors' that are seen potentially to intrude on scientific practice have persistently been difficult to keep out of the objectivist universe. Eventually, many of these 'factors' have had to be dealt with, too, and are often discussed in conferences and professional meetings as the stuff of 'co-production' or 'the contexts' of psychological therapy (see Chapter 1 and 3).

We have seen that the evidence-based framework assumes, anticipates and effects the coherence of psychotherapy. It is not designed to address empirical complexity, but to reduce complexity and multiplicity into a set of variables that can each be 'controlled' by way of converting them into numerical values in the analytical phase of the trial. Consequently, in the scientific objectification of psychotherapy – or, we might say, in the administering and representation of CBT as empirically stable and uniform – unwanted complexity is erased. This feels like a burdensome epistemology to some psychotherapists. However, therapists I met know that psychotherapy has long appeared 'messy and ambiguous' in a clinical world wherein biomedical psychiatry has sustained scientific authority in the treatment of mental health problems. It has therefore been a significant achievement to render psychotherapy into a scientific object capable of being examined in accordance with the principles of the clinical trial – thus acquiring a hard-won objectivity on an equal footing with the testing of drugs. Reducing

empirical complexity and ambiguity in this context has meant greater scientific certainty for everyone involved.

chapter six

Selfhood challenged

CBT meets mindfulness

This chapter explores the models of selfhood that evidence-based psychological therapy invites its subjects to engage with.[102] We look in more detail at some of the therapeutic specificities of psychological therapy as we move from CBT to mindfulness. This chapter examines, therefore, some features of CBT and mindfulness that revolve around a capacity to take oneself (or one's self) as an object of introspection and reflection. We will see that whilst psychological therapies in the form of CBT and mindfulness have become recognised as effective, scientifically founded interventions in the treatment of mental health problems within the framework of IAPT, they have also generated their own therapeutic uncertainties. I argue that CBT and mindfulness have come to shape conflicting models of 'the mind', with different notions of selfhood effected through these practices.

The move from CBT to mindfulness here is primarily an ethnographic one as it is informed directly by the fieldwork I undertook: when I followed the training of CBT therapists, as we saw in Chapter 4, it became clear to me that the practice of CBT had become increasingly linked with another psychological therapy that likewise had claimed an 'evidence-based' status in the UK. This therapy is called Mindfulness-Based Cognitive Therapy (MBCT), although it is more commonly known simply as 'mindfulness'.[103] Mindfulness is one amongst other evidence-based psychological therapies provided through the IAPT programme. Indeed, according to some historians (see e.g. Marks 2012; Drage 2018b), mindfulness in the form of MBCT is said to have been partly derived from CBT (as well as offering a radical reinvention of it), although

[102] For clarity, I use the word 'participant' throughout this chapter to distinguish the subjects of psychological therapy from the therapists who teach them. It is worth noting, however, that in the practice of psychological therapy, the therapeutic language tends to shift away from an explicit distinction between professionals and patients. Instead, IAPT therapists often use the term 'practitioner' to convey a more neutral position for the clinical subject of psychological therapy (which therapists might more readily refer to, amongst themselves in clinical meetings and supervisions, as 'the patient'). Part of the rationale of this shift in language is that patients are themselves becoming practitioners of CBT by virtue of learning to do CBT (or any other IAPT therapy). So, although the terms 'practitioner' tends to denote a trained therapist, it is also used to include all *practising* persons: 'therapists' and 'patients' alike.

[103] Definitions of 'mindfulness' have attracted an enormous amount of debate in recent years, amongst Buddhist scholars, psychologists, and mindfulness practitioners alike, as well as many other academic commentators, delineating histories and etymologies (for a selection of these debates, see Sharf 2015; McMahan 2008; McMahan & Braun 2017; Kabat-Zinn 2011; Loy & Purser 2013; Drage 2018a). Whilst there is no space to deal with these debates here, I should stress that my use of the term follows that of the IAPT therapists I studied: 'mindfulness' was generally used to refer to the psychological therapy of MBCT, although the practice of mindfulness was not exclusive to clinical contexts or problems, and did not always follow the eight-week course model of MBCT (Crane 2012; MAPPG 2015).

in my conversations with mindfulness practitioners, this was seen as a deeply contentious history of mindfulness. Practitioners themselves often prefer to trace a history of mindfulness back to Buddhist meditation traditions and cognitive scientists distinct from any history of CBT. Nevertheless, in most clinical textbooks and in the academic clinical psychology literature, mindfulness is often included in the plural designation of 'cognitive and behavioural therapies' and subsumed under the category of 'third wave CBT'. I will come back to these points in the following paragraphs.

So, whilst this thesis has not taken up mindfulness as its central concern (that would require another book), many of the points I have discussed with reference to CBT will have ethnographic resonance with aspects of mindfulness and its institutionalisation in the UK. I came across the practice of mindfulness in nearly all my field sites; in IAPT and NHS conferences in particular, but also in the lecture rooms on CBT, in the supervisions with students and supervisors, and through mindfulness workshops and courses advertised frequently at the South London Community Centre, and at the University of Cambridge where I returned after fieldwork.

This thesis could perhaps just have ended with CBT and stayed put there; this would certainly have made the task at hand easier but limiting my account here solely to CBT would mean leaving out a great deal of the current state of the IAPT service. First, as I pointed out in the Introduction, the term 'CBT' is often used to refer to a distinct psychotherapeutic school of thought, which itself is said to be a combination of two schools: the invention of 'cognitive' therapy in the US in the late 1950s and 60s, commonly attributed to the work of Aaron Beck and Albert Ellis, combined with 'behavioural' therapy developed in post-war Britain owed to the work of psychologists at the former Institute of Psychiatry and the Maudsley Hospital (see Chapter 2; see also Marks 2012, 2015). CBT brought together in the singular – 'standard CBT', as some practitioners refer to it in the IAPT service – has been our main focus so far.

However, CBT is also discussed as an umbrella term – often in the plural, 'cognitive behavioural therapies' – to capture different therapeutic orientations and offshoots. Some of these different orientations have been incorporated into the IAPT service as the service has expanded and evidence-based psychological therapies have multiplied. It has not been possible to deal with this elastic variety of CBT-derived therapies in this thesis nor the evaluation of each in relation to 'CBT' in the standardised singular. I mention all this here to acknowledge that there is a significant amount of therapeutic variety within the IAPT service (at the time of

writing) despite the obvious prevalence of CBT and mindfulness.[104] 'Standard CBT' is nevertheless what most IAPT therapists train in, as we saw in Chapter 4.

The ethnographic point here is that mindfulness therapy has clearly proliferated alongside CBT and other therapeutic interventions available through IAPT. Indeed, mindfulness had become so commonplace by the time I began my doctoral fieldwork that it was now frequently advertised and offered in workplaces and schools, and through other everyday instances of people's lives in the UK.[105] For example, mindfulness had apparently become so prevalent as a type of therapeutic everyday tool beyond clinical contexts and concerns that, since 2017, an in-built 'mindfulness app' has featured on the standard 'Health' section of every iPhone.[106]

We will pass through a range of entities in the following paragraphs – from cognitive distortions and sensing bodies to thoughts and core beliefs, for example – with each one worthy of ethnographic commentary. There is no space to elaborate on all therapeutic aspects of CBT and mindfulness in this chapter without omission. Rather, I have aimed to examine the aspects I feel are of particular salience for shedding some ethnographic light on the kinds of selves these therapies envision and entail, and which they in turn provide experiential confirmation of, for the people engaged in their enactment.

Some readers might feel that it has taken a long time to reach the therapeutic session itself. Some might even have wondered why we have not yet seen the 'real' practice of psychotherapy

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[104] The psychological therapies available in IAPT depends in part on which specific therapies (or 'therapeutic pathways', as many professionals now call them) have been commissioned and prioritised by NHS England's regional CCGs [Clinical Commissioning Groups]. The therapies available might vary from year to year, depending on the performance index of each local IAPT service (see Chapter 3). But, generally speaking, apart from 'standard CBT', other therapies subsumed under the umbrella term of 'cognitive behavioural therapies' typically include Mindfulness-Based Cognitive Therapy, Compassion-Focused Therapy, Acceptance and Commitment Therapy, Metacognitive Therapy, Schema Therapy, Narrative CBT, and Behavioural Activation.

[105] I had already carried out some preliminary fieldwork on CBT, as noted briefly in the Introduction, during my graduate studies in 2013 and 2014; a time also when an interest in 'mindfulness' was reaching quickly and intensely beyond its *clinical* application in IAPT (with most of the research on MBCT in the UK conducted in clinics associated with the Universities of Bangor and Exeter [see Cook 2015]). When I began the fieldwork for my PhD three years later, in the summer of 2016, 'mindfulness' had, in one form or another, secured a place and a name in various contexts beyond IAPT (see Cook 2016; Bruun 2018).

[106] Numerous mindfulness apps are also currently available in app stores on smartphones that users may download either for free or to buy. Mindfulness apps appears to far exceed an enthusiasm for CBT apps, with few of the latter available on smartphones such as *Quirk CBT* and *Moodpath*. In comparison, mindfulness apps available in the UK include *Calm*; *Headspace*; *Reflectly*; *The Mindfulness App*; *Breethe*; *Elevate*; *BetterMe*; *Mindfulness Daily*; *Self-care*, and many more. Many of these apps claim to help users becoming 'mindful' of a diverse range of purported issues from lack of concentration at work to weight gain, stress and depression, and much more; they aim generally to help users becoming more 'present' and 'aware' in the moment.

(the clinical context) or met any 'real people' (the patients), as it were. The category of 'the patient' – perhaps medical anthropology's own version of the native – more easily lends itself to the tacit notion of particular human subjects felt to be more authentically or sufficiently 'ethnographic' than, say, the scholars working in the psychology department next door.[107] I hope that I have made it clear enough throughout the thesis that I have not assumed that the therapeutic practice nor the patients are more 'real' in this sense than the mental health professionals, academics, the conferences, training course, and indeed the histories and theories, and so on, that we have followed until now. 'Patients' or 'service users' are implicated throughout the thesis, as they were during my fieldwork with mental health professionals, but they have not been dealt with explicitly; I do not intend to offer a 'patient perspective' (or perspectives) in this final chapter either, but, in an important sense, we could be said to have finally arrived amongst them.

'Watching thoughts like clouds in the sky'

Mindfulness appears to be 'quite trendy in mental healthcare', remarked a psychologist after we had witnessed an entire day of presentations on mindfulness research at a CBT conference in Manchester. One of the presenters had begun his research paper by declaring that 'mindfulness is based on ideas within Buddhist traditions going back *hundreds* of years'. 'It is time', he told us, 'that we learn from the Buddhist monks and the positive effects of meditation.' He wanted to engage his CBT audience on the reported salience of mindfulness therapy in the treatment of depression (and a range of other issues) alongside CBT.

For the keynote presentation of this same conference, the lights had been dimmed and a flowering lotus had been projected onto the screen behind the stage. As we settled into our seats, a man and a woman entered the stage and sat down on two chairs. They spoke to the

[107] It is in keeping with the lingering traditional strictures of anthropological interest at work here that some readers might feel that we are missing the 'patient perspective' in this thesis. The assumption implies that the context of the patient – i.e., people *subjected* (for example, to psychotherapy) – is where the anthropological enquiry and interest is supposed to be located. I touched on a related point in the Introduction (see p. 11) but I want to stress that it has been one of the implicit aims of this research to do away with this presupposition, which I suspect is a more common one when (medical) anthropologists seem to leave the 'the clinic' or 'the patients' – or any other such 'semantically dense' reality (Ardener 2007 [1989]) – behind. Many anthropologists have, of course, long moved on from the assumptions at work here, and ethnographic studies of professionals, academics, bureaucrats, etc., in the field of healthcare have proliferated greatly. An important point contained in the ethnography of this thesis is precisely that professionals are as interesting and as fit a subject for ethnography as are patients.

audience with calm, silky voices. The presenters 'invited' us to engage in a mindfulness exercise prior to their lecture. One of the presenters asked us to attend to our body, to its position, the support of the seat we were sitting on, the softness of the padding on the seat and, then, our breath. The title of the lecture appeared on the whiteboard above the lotus:

> *Mindfulness-Based Cognitive Therapy helps depressed individuals to access and activate the positive affect system when invited to direct compassion towards the self*

'Attend to your breath', instructed one of the presenters in a slow, soothing voice. He asked us to close our eyes and imagine our body as a solid mountain; to feel the fixed ground beneath our feet; to imagine our head in the sky, the changing weather around the mountain top, the clouds passing by… We were then asked to 'attend' to our own 'inner clouds' – our 'thoughts'. 'Bring your attention to your thoughts', he instructed, 'and just *observe* them.' 'Attentionally, but without judgement', he added. The other presenter explained how negative thoughts could be especially difficult to observe without judging or inspecting them, but the therapeutic point was to 'let them go'. 'Just watch your thoughts like clouds passing by in the sky'.

Occasions like these in the conferences I attended on CBT or IAPT were not uncommon. Mindfulness appeared to form part of many institutional contexts in which CBT was formally being put to work. Amongst the CBT students, whose training I had followed, mindfulness exercises similar to the one described above were often practised before the start of supervisions. Mindfulness approaches were also frequently discussed vis-à-vis more established CBT techniques. Mindfulness would thus be taught in the classes and supervisions every now and then for certain therapeutic purposes and to 'complement' CBT. On such occasions, the supervisor would stress that both were 'evidence-based' psychological therapies after all. Likewise, many of the university lecturers I met through the CBT course recounted how they practised mindfulness as part of their work as therapists in IAPT. They were trying to be 'mindful', they told me, when working therapeutically with patients. In staff meetings at the Community Centre in South London, we had been taught how to use mindfulness in our daily work to 'improve our wellbeing'. It was also through the Centre that I had come across a 'free' eight-session mindfulness course held in the hall of a public library located only a short bus ride away from the Centre where I lived.

The mindfulness course was led by two IAPT therapists trained in MBCT and had been sponsored by the local IAPT service as one amongst many initiatives to improve access to psychological therapy. I signed up for the mindfulness course and attended the eight evening sessions advertised, which were spread out over six months. I had already been taught a great deal about mindfulness at this point through the CBT training I had participated in, and through my reading of scientific journals, self-help books, and clinical manuals on psychological therapies; these were literatures that were not only relevant to many aspects of my research but featured also ethnographically as 'required reading' at the university course and in clinical roundtable discussions at conferences.

CBT and mindfulness are not unalike: in the context of the NHS, their provision follows similar clinical protocols, including psychological assessment and evaluation procedures, and both have been recommended by the NICE guidelines as 'evidence-based' therapies for the treatment of depression (see e.g. NHS 2018).[108] In the classes and supervisions that I followed, we learned that CBT and mindfulness are often combined in practice in the context of IAPT. At the present time, mindfulness is provided for people who are diagnosed as suffering from 'recurring episodes of depression' (3 or more episodes) or who are deemed 'currently well' but are considered 'at risk of relapse' (NICE 2019: 27–28).[109]

Furthermore, both CBT and mindfulness therapists often stress that neither therapies aims to restore the person to a permanent state of wellbeing, but that these therapies enable the person to learn to manage a range of problems over the course of their life. Such 'problems' include what might be seen as clinical problems along diagnostic lines, that is, CBT and mindfulness have variously been deemed effective for a range of conditions from depression and anxiety to chronic pain and high-blood pressure, although some of these claims remain highly contested in the scientific literatures of both fields (with only a few specified conditions currently included in the NICE guidelines [cf. NICE 2019]). However, problems are also

[108] Both therapies usually follow a programme of a total of eight therapy sessions (or twelve sessions when 'High Intensity' therapy is prescribed to the patient), although some of the therapeutic themes dealt with in those sessions vary.

[109] Mindfulness-Based Cognitive Therapy is currently prescribed to patients in the IAPT service according to two NICE Clinical Guidelines: 1) 'For people who have had previous treatment for depression [CBT and/or antidepressant medication] but continue to have residual depressive symptoms' (see CG90: https://www.nice.org.uk/guidance/cg90 [published October 2009, updated April 2018]) and 2) 'For people with a previous history of depression who are currently well and who are considered at risk of relapse despite taking antidepressant medication, or those who are unable to continue or choose not to continue antidepressant medication' (see CG91: https://www.nice.org.uk/guidance/cg91 [published October 2009]).

frequently understood and addressed in terms of 'life circumstances' or other such notions in which everything from lack of sleep to work stress, feeling insecure, distracted or uninspired, become therapeutic concerns whilst often appearing to eclipse the language of 'therapy' by defining mindfulness as a *daily practice* as opposed to a therapeutic intervention.

It is also now routinely asserted, especially in the field of mindfulness, that 'wellbeing' and 'happiness' are not 'the goal' of the practice per se. Wellbeing or happiness tend instead to be presented as an almost inadvertent positive *effect* of practising.[110] Rather, in the CBT and mindfulness courses I followed, we were told that one of the goals of this kind of psychological therapy was to become 'your own therapist'. Thus, mindfulness therapy could likewise be said to figure, like CBT, as an ideal type of a therapeutic practice that leaves the 'psyche' safely behind (see Chapter 5): as its extensive proliferation beyond the context of IAPT suggests, mindfulness appears to have divested itself quite significantly of a perceived 'social stigma' still associated with 'psychotherapy'.

In the meantime, CBT remains instructive both as the founding therapeutic framework of IAPT and in terms of its wider influence on other psychotherapeutics in the UK, including mindfulness therapy itself. And yet the popular appeal of mindfulness seems often to eclipse this prevalence of CBT. Mindfulness has been introduced extensively into public health services in the UK, including training programmes and large-scale research investments, and beyond: mindfulness features widely on social media, in smartphone apps and self-help books. Many institutions in the UK such as universities now also include and advertise mindfulness courses, which are offered to help students 'cope' with 'exam-stress', to 'enhance' their 'mental performance', achieve a better 'work-life balance', and so on. Ethnographers have already begun to comment on the recognition of mindfulness beyond its clinical application; alongside CBT, it appears to have become one of the most favoured forms of therapy or 'self-care' in the UK and elsewhere (Cook 2015, 2016, 2017; Drage 2018a; Vogel 2017; Wheater 2017).

Whilst advocates of mindfulness have typically wanted to see it as a therapeutic practice with ancient origins in Buddhist meditation practices (e.g. Kabat-Zinn 2011), it seems to have been developed as a form of psychological therapy in the late 1990s (Drage 2018b) by cognitive scientists and Buddhist meditation practitioners, the one encouraging the other. Amongst

[110] For example, Cook has described how the 'positive effects' of mindfulness are 'achieved through ongoing self-reflexive work by which the immediacy of life in all of its extraordinary ordinariness may be appreciated' (2015: 232).

these practitioners, four men feature as the 'founding fathers' of MBCT: John Teasdale and Mark Williams, based at the universities of Cambridge and Oxford in the UK, and Zindel Segal in Canada and Jon Kabat-Zinn in the US. In 2004, following two randomised control trials (Ma & Teasdale 2004; Teasdale et al. 2000), mindfulness was given some scientific credence and recommended by NICE. Mindfulness therapy is currently provided in the IAPT service in the form of group-based therapy sessions led by one or more MBCT-trained therapists over the course of eight weekly two-hour sessions.

There were mental health professionals at IAPT conferences who saw mindfulness as a direct rival to CBT, and some blamed it for having obliterated the 'behavioural' component of CBT. Some remarked at these conferences dryly that mindfulness was just another hype: 'these fads come and go', retorted one psychologist to me after a conference paper on the benefit of mindfulness to prevent stress amongst primary school children. She went on to cite a list of recent publications that had apparently hit back at the 'hype'. In the case of mindfulness, this kind of criticism seems to have been especially controversial as the evidence-base for the proclaimed effectiveness of mindfulness has more recently begun to come under scrutiny. There is an increasing number of scientific publications in the fields of clinical psychology and neuroscience that appear to challenge the established place of mindfulness in the category of 'evidence-based' therapy and its endorsement in the NICE guidelines; *Mind the Hype: A Critical Evaluation and Prescriptive Agenda for Research on Mindfulness and Meditation* is the title of one such recent publication (cf. Van Dam et al. 2018). Referring to the self-same methodological standards of EBM with which mindfulness research is assumed to be compliant, the critics have found significant faults with some key features of mindfulness research and 'the evidence' it has presented.

During my fieldwork I became aware of psychologists and neuroscientists and other scholars – many of whom are openly mindfulness practitioners themselves – who had been met with a notable backlash from 'the international mindfulness community', as one of the scholars put it. The 'Mind & Life Institute' is one such mindfulness community of scientist-practitioners, in its own terms, which claims to build a 'scientific understanding of the mind in order to reduce suffering and promote wellbeing',[111] but one which has also become known for 'censoring' those scientists who have questioned the scientific integrity of mindfulness research

[111] See https://www.mindandlife.org/people/ (accessed January 2017).

or the clinical recommendation of mindfulness as a form of psychological treatment (see e.g. Britton & Lindahl 2019). Certain critiques of mindfulness, then, especially of its promotion as an evidence-based psychological therapy in the UK – and, in particular, with regards to certain aspects of its Buddhist underpinnings (see Drage 2018a, 2018b) – have also been met with some hostility from prominent members of the scientific mindfulness community, many of whose senior members identify as Buddhist practitioners.

Similar tensions were also played out in the mindfulness sessions themselves that I participated in. On one such occasion, for instance, other participants in the group reacted with scepticism to the explicit links that the therapist kept drawing between mindfulness as a form of 'secular therapy' and its 'Buddhist legacy'. One woman stood up halfway into one of our first exercises when the therapist enthusiastically told us how 'we should all be more like the Buddhist monks'. The woman in question tried to leave the room quietly and excused herself: as a Christian, she explained, she did not feel comfortable participating in the mindfulness practice since it was clearly also 'spiritual'. She pointed out that she had signed up for the course because of 'all the science behind mindfulness'. She was interested in the therapeutic effects of psychological therapy, she told the therapist, but felt uncomfortable 'engaging in Buddhism'. The therapist tried to persuade the woman to stay, insisting that mindfulness had nothing to do with 'religion'. On the contrary, it was 'secular' and 'scientific'. The sceptical woman took her seat again, but she never returned to the sessions.

We see at work here a tension in the practice of mindfulness with its own scientific persuasions whereby 'science' cannot easily occupy the same domain as 'religion', with the latter posing as a problem for claims to scientificity and therapeutic impartiality. Religion and science still can, and does, pose as a familiar a world wherein psychology strives to be 'objective' – it is a division with an apparently long and troublesome history (see Hardin et al. 2018).

The MBCT sessions and public workshops I followed on mindfulness were predominantly attended by women, many of whom were in their 30s and 40s, or older. On many occasions, I was the only male participant in groups of between five and fifteen people.[112] After a public mindfulness workshop I attended in London, I asked one of the presenters, a psychologist, about the female-male ratio in mindfulness therapy versus CBT, to which she replied that, in contrast with the 'forceful intervention' style of CBT, mindfulness offered a 'softer', more

[112] The predominance of female participants in the mindfulness sessions I followed resonates with other studies of mindfulness conducted elsewhere in Europe (see Vogel 2017, on a Dutch mindfulness course)

'compassionate', approach to psychotherapy and one which, therefore, appealed to a lot of women.[113] Whilst mindfulness can thus pick up traditional notions constituting femininity, and appeal thereby, CBT can elide with masculinity. CBT was quite often described as being more 'masculine' in its therapeutic approach and requirements, with all its talk of 'action plans', 'rational inspections', 'thought records', 'goal-settings', and so on. The 'attention-' and 'compassion'-focused therapies to which mindfulness is seen to belong are commonly described as constituting a 'third wave' of cognitive behavioural therapies (Marks 2012). Some therapists I met felt that 'third wave CBT' had inserted all the missing 'feminine' aspects of psychological therapy, not least of which was an attention to 'emotions' and 'the body' – and to 'attention' itself.

There are important differences between the psychological therapies of CBT and mindfulness, which go beyond any gender elisions. These are differences concerned with the ways in which people are asked to engage with their reported distress or other problems: the kinds of interventions they are asked to make on themselves and the shape and significance of 'the mind' and 'self' effected through these. The rest of this chapter examines these therapeutic specificities of CBT and mindfulness, asking what kind of 'selfhood' is sought or wrought through engaging in their practice.

Models of the mind

A shift from CBT to mindfulness reveals serious therapeutic tensions as different models of 'the mind' are articulated and effected through the assumptions, requirements, and claims that constitute these practices. In CBT and in mindfulness, as in other cognitive therapies, 'thinking' and 'thought' elide with a conception of 'the mind' at work here. First, we will be moving further into some ethnographic descriptions of CBT and mindfulness therapy before probing some issues concerned with the significance of 'reflective thought', 'metacognition' and 'self-care'. We finally arrive at anthropology's relationship to psychology, exposing a pressing question implicated in this thesis: what it might mean to do an anthropology of psychology.

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[113] The view eclipsed the fact that mindfulness as a form of psychological therapy – MBCT and MBSR [Mindfulness-Based Stress Reduction] – seems to have been designed exclusively by men (see Drage 2018a, for biographical histories) with women appearing to have been involved only in its promotion – such as, for example, Rebecca Crane at *The Centre for Mindfulness Research and Practice* at Bangor University (see e.g. Crane 2009, 2017).

CBT: the self as rational inspector

'Change your thoughts'

On the training of IAPT therapists in Chapter 4, we saw that CBT presents, in its most condensed form, a tripartite model of human psychology consisting of 'cognition', 'behaviour' and 'emotion'. We saw how these three concepts define and explain the practice of CBT in delineating the content and form of a universal 'human psychology'.[114] When we move to the CBT sessions themselves, participants are learning to practice CBT much like the therapists themselves have been taught it. In the therapy sessions I participated in, we were taught to identify 'distorted' patterns of thought in order to then inspect and evaluate them so that 'negative thoughts' can be replaced with ostensibly more 'accurate' cognitive habits that do not lead to negative emotions and behaviours.[115]

This basic theory of CBT is evoked in many other instances outside the sessions themselves where some form of CBT is being put to work; for example, a best-selling self-help book states clearly this approach with the title: *Mind over Mood: change how you feel by changing the way you think* (Greenberger & Padesky 2016 [1995]). A typical CBT exercise in such self-help books might involve filling out a flowchart to identify self-critical 'automatic responses' that occur whenever you face a setback, like being criticised at work or rejected after a date. Other exercises might involve learning 'coping strategies' to manage 'symptoms' that are seen to be characteristic of a disorder that has already been diagnosed through IAPT's assessment procedure (see Chapter 3). In the sessions, as in the self-help literature, participants and readers are thus asked to be *reflective* by engaging in a practice of introspection by which perceived negative thoughts are interrogated 'critically and rationally'. The aim is to 'challenge' those thoughts that are experienced as 'negative' in order to 'change' them.

CBT is usually provided in sessions of one-to-one consultation (which last between 45 and 60 minutes each) if a person is referred to the IAPT service as a 'patient' and is diagnosed with a 'moderate' to 'severe' mental health problem. Patients who are diagnosed with a 'mild' to 'moderate' mental health problem (such as 'work-related stress') might be placed in the

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[114] Cf. Beck & Rusheds (1979); Clark and Fairburn (1997); Neenan and Dryden (2014).

[115] It is rarely explicated in CBT what exactly counts as adaptive or healthier thoughts, but they are always contrasted with 'maladaptive' or 'negative' thoughts. The latter are often discussed as beliefs that are held irrationally, with the implication that changing or adjusting them means greater accuracy between 'cognition' and 'reality' (see also Chapter 4).

category of 'Low Intensity' [LI] intervention and offered group-based therapy combined with CBT exercises on a computer (cCBT). Therapy sessions are usually offered on a weekly basis, with 'treatment plans' lasting between 6 and 14 weeks. The structure of the sessions is fairly standardised – through the training together with the professional conferences, NICE clinical guidelines and IAPT manuals of the kind we have seen – across the range of mental health problems that are assessed and treated in the service.

At the first session, participants are typically asked to formulate the problems they most want help in solving and, assisted by the therapist, they then devise an 'action plan'; this is a process that is discussed amongst therapists as a 'collaborative case conceptualisation' or 'intervention strategy'. The experience of any difficulties on the part of the patient that might arise over the course of therapy are discussed in what is seen to be a 'problem-solving' and 'goal-orientated' manner. The action plan usually catalogues prescribed 'homework' in the form of various 'self-help' strategies and behavioural exercises that the patient has agreed to work with outside the sessions. This homework is seen to involve the deliberate practice of new 'cognitive' habits. The idea is that, as the patient progressively learns to 'apply' the 'techniques' of CBT, the patient becomes a *practitioner* of CBT of some sort.

A central feature of CBT therapy entails identifying 'problems' that may be as diverse as 'lack of self-esteem' or 'bereavement' or identifying 'symptoms' such as 'insomnia' and 'rumination'. There is no easy demarcation here of the 'mental health problems' that a patient might report or the 'problems' that might form part of a diagnostic assessment and then feature in subsequent sessions as 'symptoms' of a discrete mental disorder. For example, 'problems' identified by the participants – lack of sleep and appetite, for instance – might be construed as ordinary 'life stressors', thus in terms that are quite different from those problems that are construed as 'symptoms' of a 'disorder'. As such, a participant's reported experience of lack of sleep and appetite might in one context be dealt with as a result of 'stress'; in another it is a core symptom of 'depression'. However, both problems and symptoms become in practice part of the same theory of 'distorted cognition' or 'negative thoughts', and subject to the same general technique of rational inspection.

Rational inspection involves the use of different working materials, most important amongst these being the 'thought record'. These records are worksheets that are seen to provide the best practical tool to rationally evaluate and interrogate negative thoughts. Patients are asked to fill out thought records through which they record, in writing, the content of the negative thoughts

they experience; these are typically summarised as brief statements that are referred to as 'negative core beliefs'. The statements might seem as heterogeneous as the 'problems' that shape them; 'I am not a good dad', 'I will fail my exam', 'no one loves me', and 'life is meaningless', were some of the examples that had been written on patients' thought records in the CBT supervisions I followed. The CBT thought record claims to take the patient through a step-by-step evaluation of the content of each negative thought and to conceptualise thoughts as 'responses' to a given situation or environment.

The rational inspection then proceeds in which the patient is asked to provide 'evidence' against the negative core belief. To put this simply: if one's negative core belief is that 'no one loves me' one might be asked to formulate new statements – 'I do have friends who love me', 'I know my children love me', and so on – that 'prove' the negative belief wrong. The therapist assists the patient throughout this rational inspection in which the 'accuracy' of the content of a negative thought is constantly questioned. We were repeatedly asked to observe and reflect on our own thoughts in an effort to actively *change* them. The aim here was to 'cultivate' what is understood to be a more accurate set of core beliefs: more positive cognitive habits. The therapeutic goal was thus seen to revolve around an inspection of the *content* of thoughts.

CBT invokes here common conceptions of selfhood that are already meaningful in the UK beyond the context of mental healthcare. It is perhaps not surprising that the therapeutic language of CBT and the language of accountability and managerialism concur: 'managerial' and 'entrepreneurial' selves – subjects capable of self-care, self-control and self-help – have been important inventions of a similar period (Foucault 1991; Rose 1996). They came into being particularly in alternative worlds constructed in rebellions against centralised state structures and reliance on 'the State' during the late 1960s and 1970s; they have also been given life in the 1980s through the very different 'new public management' reforms in the UK, and a neoliberal 'rolling back of the state' (Hood et al. 1999). It was during these same decades that cognitive and behavioural psychotherapeutics where developed and combined into 'CBT' (Marks 2012). A distinctly new language of the clinical subject was forged in which ideas of self-help and self-inspection became particularly instructive and redefined 'mental healthcare'.

It is also in the diagnostic assessment of patients in the IAPT service, through the use of 'patient health questionnaires' (e.g. PHQ-9 for the diagnosis of depression, see Figure 1), that we see a self construed as a rational inspector. In other words, a patient's experience of distress is extracted through standardised, itemised questionnaires that render 'patient experience' into

numerical quantities that align with symptomatology – that is, a set of symptoms that are seen as characteristic of a psychological condition exhibited by the patient.[116]

CBT's reliance on this technology of measurement and quantification assumes a reflective patient with a capacity also to perform self-assessment; it assumes an introspective and reflexive self; a subject willing and capable of reporting on their own experience – understood as 'thoughts', 'feelings', 'behaviours' and 'physical sensation' – confirming, in turn, the basic CBT model of human psychology. Psychological questionnaires, often combined with other documents such as informed consent forms, action and goal-setting plans, patient journals, and so on, can thus be seen as constituting a 'formal regulatory rendering of a subjectivity' (McDonald 2014: 136); a particular kind of subjectivity which is already taken for granted in many other contexts where audit and accountability, (bio)ethics and bureaucracy come together (see e.g. Reubi 2012; Riles 2006; Strathern 2000).

The psychological questionnaires which are typically used throughout the CBT sessions could thus be said to configure and reify the very subject it assumes: an individuated mind-in-a-body composed of a universal human capacity to take 'thoughts' as objects of reflection and inspection. Such proprieties are consolidated experientially and contextually in particular material and conceptual circumstances – first and foremost in the therapy sessions, but also beyond the clinic – wherein self-report and self-inspection are taken as axiomatic human capabilities. Importantly, this capacity of in(tro)spection assumes an interiority of the human subject as the locus of an individual psychology or 'mental health' – the object of introspection.

This requirement to self-report and self-inspect – in a sense, to make the self accountable – might well be reinforced in other areas of people's lives in the UK, such as in daily working practices of self-checking and self-management. The pervasiveness of CBT was further conveyed to me when I returned to Cambridge after fieldwork in 2018 and discovered that my Department's website had been updated with a 'Student Wellbeing' page on which 'wellbeing' had been formulated according to the model of CBT; there was no explicit mention of 'CBT' however, but its model of human psychology was nonetheless clear. The statement on the website reads, using the language of CBT:

[116] The most established type of questionnaire used in psychological assessment is based on Thurstone and Likert scales developed in the 1920s and 1930s; for a detailed account of these, see Young (2017). Patient questionnaires in IAPT are commonly referred to as 'identification tools', 'measures' or 'scales'.

Signs and symptoms of mental health and wellbeing issues include:

Thoughts: difficulty concentrating; disruptive, interrupted or racing thoughts; difficulty making decisions; negative thinking; lack of self belief.

Feelings: reduced self-worth; prolonged sadness; rapid mood changes; anxiety; panic; increased irritability; feelings of being overwhelmed or out of control.

Behaviour: lack of motivation; being tearful; less active; disorganisation; social withdrawal; difficulty falling or staying asleep; poor work/life balance; agitation.

Physical: fatigue; lethargy; tremors or palpitations; difficulty breathing; weight loss or gain; lack of appetite.[117]

However, although CBT is available in Cambridge through IAPT's scheme of self-referral (see Chapter 1), as it is everywhere else in England, it is mindfulness therapy – not CBT – which is advertised by the University's psychological services. Since 2019, mindfulness therapy has been offered to students by all Cambridge Colleges, organised by the University's extensive 'Learning Mindfulness at Cam' initiative, which runs an IAPT-based eight-week course each term (i.e., weekly group therapy sessions). Mindfulness is described here as a 'well researched and effective approach to improve well-being'; as a 'natural human impulse to be aware'; and as a 'secular approach to meditation'.[118] It is further explained on the University's website that mindfulness therapy is about developing a 'regular practice' much like 'learning a language' or 'going to the gym'.[119] The goal of the practice is summarised as such:

> Mindfulness is about learning to accept what happens inside you in a self-accepting way, *not getting rid of it* [ibid.; my emphasis]

We could say, in summary, that the person is constituted here as an autonomous, self-determining 'individual' with a capacity to reflect. Secondly, 'mental health' is understood to refer to a particular kind of experience in which subjectivity is located in the 'inside' of a human being. The sense of self is a sense of interiority. And finally, we see at work a 'self' construed in managerial terms: the self in charge of itself. In CBT, the therapist takes the role of the metaphorical manager who teaches people to become managers of their own lives.

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[117] 'Student Wellbeing', https://www.socanth.cam.ac.uk/about-us/student-wellbeing [accessed January 2018).

[118] 'Learning Mindfulness at Cam', https://www.cambridgestudents.cam.ac.uk/welfare-and-wellbeing/mindfulness-cam/learning-mindfulness [accessed August 2019]

[119] 'What is Mindfulness', https://www.cambridgestudents.cam.ac.uk/welfare-and-wellbeing/mindfulness-cam/what-mindfulness [accessed August 2019].

In mindfulness, as we will see, it is not so much 'management' that is sought through the therapeutic practice, but rather 'detachment'.

Mindfulness: the self as detached observer

'I am not my thoughts'

In one of the eight-week courses I attended on mindfulness, we were invited to participate in 'guided meditations' as one of the central techniques of the therapy. Meditation was seen as integral to the psychological therapy we were engaged in and was presented as offering us a way of learning and practising mindfulness beyond the scheduled sessions of the course. Meditation exercises also formed part of our daily 'homework' between sessions. We were instructed that it was on the basis of active participation in the sessions as well as doing the assigned homework that we could begin to develop 'a new kind of relationship with ourselves' through 'cultivating' new ways of relating to our 'Thinking Mind'.

In the first of eight sessions I followed, we were introduced to a couple of therapists who would lead the sessions. Two of the therapists were trained as clinical psychologists and the other had first trained as a nurse before qualifying as a psychotherapist in IAPT. Christina, one of the psychologists, introduced the course: 'Mindfulness is very uncomplicated', she began, 'it's logical, and it's basically free: you can do it anytime and anywhere. It is a way of thinking and a way of being.' Christina went on to describe how mindfulness means paying attention in the present moment, 'attentionally and non-judgmentally'. In this eight-week programme, as in the many other mindfulness workshops I had attended, we were told that mindfulness is about realising that 'thoughts are just thoughts: I have thoughts, but I am not my thoughts'.

Drawing on particular strands of East Asian Buddhist philosophy (see McMahan 2008), MBCT teaches a notion of 'the self' which is not reduced to or composed of the 'thoughts' or 'cognitions' that pass through a 'thinking mind'. Thoughts are described through spatial metaphors in which we attend to them like 'clouds in the sky'; clouds come and go, they make their appearance: clouds can be dark and grey, at other times they are bright and white. The sky, however, is not made up of its clouds – it has clouds. During these sessions, then, we were gradually practising and learning techniques that reaffirmed how our 'mind has thoughts', but 'is not its thoughts'. We were taught that thoughts, like clouds, can be observed. This required a 'detached' perspective (cf. Cook 2015) on a perceived mental or psychological interiority; in other words, it required an objectification of thinking in terms of thoughts seen as 'mental

events' occurring in the interiority of our being and not seen as 'a reflection of the self'. Christina continued: 'We can watch our thoughts, acknowledge them compassionately, and then gently let them go'. It was through the metaphorical language of 'the sky' versus 'passing clouds', that we were asked to attend to thoughts as 'not really real'. The sky – our 'real self' – was perceived to be, within the metaphoric, somewhere above the clouds.

Each session began with a guided meditation lasting half an hour, in which we were asked to 'sense' different body parts through 'mindful breathing' and 'mindful attention', travelling from the feet on the ground to the top of our heads – a technique referred to as the 'body scan'. As we were 'scanning' each part of our bodies, the therapist 'guided' us to distance ourselves from any 'worries' and 'distracting thoughts' by reminding us to constantly bring our attention back to our breath:

> Once again, if you notice your attention wandering, just make a mental note of where it's going… and when you do that, just very gently then bring your attention back to this moment as you are sitting here.

We were reminded that our breath is with us all the time, even though we are not always aware of it. We were told to focus on 'the breath' whenever we noticed that our 'mind' wandered off, to bring our attention back to it 'like an anchor'. Through the metaphorical anchor and attention to breathing, we were then asked to attend to an internal awareness of our 'self':

> Sometimes when our mind is very active or we feel anxious and depressed, we know that our breath is always here like an anchor. We can always bring our attention back to our breath and thus become aware of ourselves.

Attention to breath and breathing thus appeared, in practice, to be akin to gaining a sense of self. This awareness of a 'self' was contrasted with 'negative thoughts' as events. Negative thoughts were described as the product of the 'auto-pilot mode' of a mind out of order: all the fearful, insecure, dominating, lazy, perfectionist or deprecating parts of a person perceived to have emerged and taken control somewhere during the course of one's life. Being caught up in thoughts was frequently explained as an effect of a 'doing mode' of mind as opposed to a 'being mode'. Contrary to CBT, in the mindfulness sessions we were asked to cultivate the self's ability to *observe* and *detach* from the content of thought as opposed to interrogate and change it. We

were learning then to 'be' with our thoughts, feelings and sensations, rather than 'do' them as it were (e.g. react or act on negative thoughts). The 'being mode' that was sought to be cultivated in the sessions was explained in instructions such as telling yourself that '*it* [thinking a thought] *is OK*. Just gently observe it and then let it go. Watch it pass'.

Negative thoughts – sometimes spoken of in the metaphoric of internal critics – were said to be dealt with therapeutically through the practice of 'decentring'. Decentring is a technique that is seen to depend on an ability to 'observe' thoughts intentionally and non-judgmentally in an effort to 'distance' oneself from them. It was through learning to practise this 'detached' perspective that one would eventually be able to decentre the mind from its thoughts, which would then instead appear as objects of observation – and hence experientially distinct from a sense of self.

As we reached 'the head' in these guided meditations, we were asked to relate to our thoughts in the particular way we had learned in previous sessions: to observe them with 'detached curiosity', to allow them to be there – 'it is OK: I have thoughts, but I am not my thoughts' – watching the thoughts pass like clouds and finally disappear. When participants described themselves as 'having a thought' in these terms, they were reifying an important idea of selfhood evoked in mindfulness therapy. Notably, that thoughts are not 'real expressions' of who you are or of reality, but that they are instead to be seen as 'events'. We had learned that we could distance ourselves from thoughts through attention to breathing rather than thinking, and by visualising thoughts as 'drifting by as clouds in our heads'. Participants generally felt that it was important to learn to relate to thoughts as metaphorical 'clouds' in order to experience them as 'events'. But it was also deemed a difficult task.

The participants on this mindfulness course were in the progressive process of acquiring an ongoing experience of an internally consistent and authentic mind-body-self construed as separate from the thoughts of its own making. The perceived tendency amongst people to conflate 'thoughts' with 'selfhood' or 'reality' (discussed by some of the psychologists as a propensity of 'human cognitive experience') was the assumption against which mindfulness presented its therapeutic objective: to experience thoughts as just 'thoughts', as not really 'real'. It was also what participants found most difficult to achieve.

This was evident when, at the end of each meditation, the therapist asked us how we experienced the exercise, and to reflect on the progress of our mindfulness practice in the past weeks. We were asked to share and evaluate our experiences with the rest of the group. Below

is an extract from one of these many 'evaluations' (this one is taken from a session half-way through the eight-week course):[120]

'So, what was it like doing the exercise today?', asks the therapist.

'It was difficult', replies one of the female participants. Others nod in agreement.

'Why was it difficult?', asks the therapist.

'I guess it was very difficult because I've been running around all day, and now I was asked to just sit down and stop my mind racing,' the woman responds.

'Yes, stopping your mind racing – what was that like?', asks the therapist.

'Well, I know it's a good thing to do…' The therapist intervenes: 'So that's your thinking mind right there, but what did it feel like?'

'Well, I enjoyed it,'

'You enjoyed it, good'. 'How did the rest of you find it?', she says looking at the others in the group.

'It felt peaceful', another woman replies.

'Peaceful', repeats the therapist, 'Good, thank you. That's positive. Anyone else? What did it feel like bringing your attention back to yourself?'

'I was distracted a lot by my thoughts', says another participant, 'they [thoughts] still seem very real to me.'

Another participant nods and adds: 'I feel you have to have a lot of control over your attention all the time. It's difficult. It's not just something you do automatically. It's a bit easier now than in the beginning [of the course], but I still find it quite difficult to practise when I leave the sessions: I'm not really present with myself — I am often in my head with my thoughts.'

'In your head. That's very interesting… so you were thinking a lot when you first started [the course]?'

'Yes. I'm still trying to distance myself from my thoughts, but my attention shifts all the time.'

Both CBT and mindfulness explain depression as the result of 'maladaptive cognitive functions'.[121] The self, and relation to self, that people are asked to engage in, however, differs

[120] This is constructed from notes and a recording of the session; this recording was made with participants' permission, of course.

[121] For example, as one of the psychologists put it: 'One of the reasons why mindfulness is very helpful for people with long-term depression, is that people with long-term depression are very often in their heads; they are often ruminating a lot and critically-thinking. When we practise meditation and mindfulness, we can be where our attention is, and we can see where it is going — if it is focusing on thoughts that are not very helpful. And we can then stop it [the attention] going down that channel, and we can learn to attend to ourselves in a different way by learning to be in the present moment. We can learn how to respond [to

between the two types of therapy. In CBT, 'negative thoughts' are taken seriously; that is, they are rationally examined and evaluated in an effort to 'adapt' or 'modify' their content for the better – for a better self. We could summarise this stance as suggesting that (negative) thoughts are 'real' as they are seen to have experiential effects. In mindfulness, on the other hand, 'thoughts' of any kind are not granted the same ontological status: the patient is asked not to examine or evaluate thoughts but to 'watch' and 'observe' them in the present moment, to separate them from a sense of self.

On many such occasions during the mindfulness course, it was brought out how this separation of 'thoughts' and 'self' – a stance which demanded a simultaneously 'detached', 'compassionate', and 'non-judgemental' perspective on thoughts as 'drifting events' – was difficult to experience beyond the meditation practice itself: 'When I'm doing the meditation I know that the thoughts I have are not necessarily a real reflection of who I am: that I am not my depression. But most of the time, my thoughts – the good and the bad – feel part of who I am. They are real.'

In mindfulness, you are asked to evaluate not the contents of your thoughts but instead to attend to a specific kind of *relation* with and *perspective* on your thoughts. Thus, over the course of learning mindfulness, people are explicitly asked not to challenge and change their 'negative thoughts', as in CBT, but to observe them: 'watching thoughts like clouds in the sky'.

Cognitive cultivators: 'Reflective thought' and 'metacognition'

When moving from CBT to mindfulness, we are required then to cultivate an ability to 'watch' our thoughts, located in what is understood to be a cognitive 'inside'. In the therapy sessions of mindfulness, as with CBT, we thus encountered a notion of selfhood that locates and forges an individuated self in a psychological 'interiority' (Navaro-Yashin 2012) or 'inwardness' (Taylor 1989). It is the way in which participants in CBT and mindfulness are asked to engage with and experience such an interiority that is of interest here. An ethnographic shift from CBT to mindfulness, I suggest, presents us with a therapeutic shift that turns on a question of the significance granted to 'thoughts' and the position of the subject towards thinking.

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depressive thoughts] in a more helpful way. That's one reason why mindfulness is helpful for treating low mood and depression. A lot of people who suffer from low moods are quite distracted from their own emotions and they are in their Thinking Mind a lot of the time. And when they are thinking and ruminating a lot of the time, they are actually missing a lot of what's lovely to enjoy in life, for example, even walking down the street or tasting a meal.'

In the practice of both CBT and mindfulness, participants were tacitly asked – 'guided' or 'invited', as therapists put it – to understand their subject position as a case of 'becoming your own therapist'. People were asked to take up a position as a kind of cognitive cultivator. This generally involved, in the therapists' terms, cultivating your abilities to 'work' on yourself by engaging in what therapists variously described as 'psychological homework', 'mental fitness', and 'dedicated training'. The now very common references to 'physical fitness', 'going to the gym', and the like, seemed to provide a powerful metaphoric for therapists in describing what 'working on yourself' might mean in psychological therapy. This analogy between physical and mental health is reinforced in a common therapeutic language with the talk of *exercises*, *techniques* and *sessions*. So rather than being talked about as 'psychological intervention', for example, mindfulness therapy is often presented to participants as a series of 'mindfulness *exercises*'. 'Working on yourself' and 'becoming your own therapist' involved becoming a *practising* subject (analogous to the gym-goer). In a popular self-help book, for instance, clinical psychologists Elaine Foreman and Clair Pollard introduce CBT as a form of psychological 'workout' through which 'you really can sharpen, tone up and keep your mind fit by regular workouts at the mental gym. […] Your workout strengthens you as you develop new qualities and performance-enhancing, stress-reducing, life-improving beliefs' (Foreman & Pollard 2011: 10).

As we have seen, the central therapeutic instruction in mindfulness requires the participant to take up a detached perspective on 'negative thoughts' through which thoughts are construed experientially as metaphorical 'clouds'. That is, the aim is to *not* experience your thoughts as reflecting your 'self' – thinking as an aspect of selfhood, we might say – but rather as a series of events that occur in the cognitive interiority of an observing self at the centre of mental activity. We are reminded of the metaphor of the mountain top (the self) around which revolves the changing weather (the mind or thoughts). This specific kind of detachment entails an *objectification* of 'thoughts' and a subject/object dualism demonstrated by the construal of the self as an observer, on the one hand, and the observed (thoughts/cognition/mind), on the other.

Importantly, it is through this dualist rendering of the subject as an observer combined with a detached perspective towards the thoughts that people in mindfulness therapy are asked to view thoughts simply as 'mental events'. Regardless of the *content* of your thought – the content of what your internal critics might tell you – for instance, 'I am useless at my job' or 'I will never love again', the participant is asked to view these as simply mental events: as events that do not

in any way reflect an 'I' – a self. We were, in other words, asked to engage in an experience of selfhood detached completely from our thoughts that were said to pass through our minds.

Thoughts were thus rendered into *objects of observation* distinct from the observer. Repeatedly, however, participants I spoke with over the course of my fieldwork in these sessions found this stance particularly difficult to maintain. Participants expressed how they were used to identifying their experience of thoughts as part of a sense of self. For these participants, 'self' and 'thoughts' were difficult to separate; it was difficult to uphold a totally 'detached' perspective on thinking as distinct from the thinker. Mindfulness therapists generally responded to such unease by stressing that what mattered was that we were trying to pay *attention* to our mind by observing our thoughts, on purpose, and without judgment. Importantly, this stance was contrasted with the encouragement found in CBT to interrogate the content of your thoughts. 'I *have* thoughts, but *I am not* my thoughts', was the key mantra here that mindfulness therapists constantly asked participants to repeat when experiencing negative thoughts. This ability to detach or decentre from what was perceived to be 'internal' experiences thus relied on the objectification of 'thoughts' through the ascribed meditations of 'watching' and 'observing'.

As we saw in the mindfulness exercise at the beginning of this chapter, techniques of watching and observing without inspecting or judging were taught through the use of metaphors and visualisations whereby thoughts-as-events were attended to visually and perceptively as 'air'-like attributes of 'the human mind': clouds, the sky, the weather. We return to the implication of this spatial topography and its moral definition in a moment.

Anthropologists have only recently begun to study the therapeutic practices of evidence-based psychological therapies. In her study of an MBCT course at the University of Exeter, Cook presents mindfulness therapy as a cultivation of a cognitive mode of detachment, which results in a renewed engagement with the world and a sense of self (Cook 2015). She describes how mindfulness 'is understood as a way of cultivating a skillful engagement with life, reconfigured as a technique of self-discovery and self-transformation, as well as physical and mental health' (Cook 2015: 227). Cook argues that the effect of this therapeutic work is akin to the significance of 'reflective thought' in Foucault's theory of ethical self-cultivation (Foucault 1988d, 1997: 223–301). According to Foucault, the capacity of conscious, reflective thought is what constitutes 'the very stuff of ethics' – namely, 'the relationship of the self to itself and the relationship to the other' (Foucault 1997: 300). Foucault writes:

> [Thought] is what allows one to step back from this way of acting and reacting, to present oneself as an object of thought and to question it as to its meaning, conditions, and its goals. Thought is freedom in relation to what one does, the motion by which one *detaches oneself from it, establishes it as an object,* and reflects on it as a problem. (Foucault 1997: 117; my emphasis)[122]

This idea is taken up by Cook and described in the therapeutic practice of mindfulness, with reference also to an anthropological literature on the question of ethics and freedom (especially Laidlaw 2014). The practice of cultivating a detached perspective on one's thoughts is theorised as taking 'the form of an aspiration towards and training in reflexive self-consciousness', which, Cook suggests, lies in 'the relationship that the participant has with his or her own internal responses' (Cook 2015: 220).

The ethnographic forms of ethical reflexivity and self-care that are alluded to here are suggestive of similar points made in my own anthropological writing concerning the therapeutic work of clinical psychologists (Bruun 2013). I have previously described the therapeutic relationship of psychological therapy as a way of imagining and practising self-other relations which constitute an ethical process as the clinical subject gradually learns to envisage and enact new modes of being and relating to self and others. This involved, in turn, the cultivation of an 'ethical sensibility' on the part of the therapist (ibid.: 27-29).

In her ethnographic study of a 'mindful weight loss' course in the Netherlands, Else Vogel (2016) has similarly drawn on Foucault's notion of ethical self-cultivation in her approach to mindfulness-based therapy. Vogel refers specifically to what Foucault called the 'arts of existence' and cites a quotation from the second volume of his *History of Sexuality* (Foucault 1992):

> [T]hose reflective and voluntary practices by which men [sic] not only set themselves rules of conduct, but seek to transform themselves, to change themselves in their singular being, and to make their life into an oeuvre that carries certain aesthetic values and meets certain stylistic criteria. (Foucault 2012: 10–11, as cited in Vogel 2016: 4).

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[122] Crucial to Foucault's theorisation of 'ethics' as 'reflective thought', is the understanding, as Cook points out, that what is meant by 'thought' is not limited to the content of thinking, which he recognises as culturally and historically contingent.

The idea of 'reflexive self-consciousness' sought in mindfulness therapy, as described by Cook (2015: 220), and the orientation towards the potentialities of 'self-care' and 'self-transformation', as described by Vogel, emerge as ethnographic instantiations of Foucault's 'technologies of the self' (Foucault 1988d): 'to make oneself into a certain kind of person', as James Laidlaw has put it (Laidlaw 2002: 321–322).

Thus, the combination of techniques, comportments and narratives that make up mindfulness introduce a specific model of selfhood: an individuated self-in-a-mind-body comprised of 'cognition', 'emotion' and 'sensations', complete with a 'reflective consciousness'. Both Cook and Vogel leave us with anthropological accounts of psychological therapy that both presuppose and enable a notion of the self in these terms, construed most importantly as the capacity for detached reflection. The subjects of psychological therapy, then, turn out to be Foucauldians in pursuit of some form of ethical self-cultivation.

I want to underline four main points here. Firstly, in CBT and mindfulness, selves are talked about as inhabiting 'individuals' and self-cultivation is seen as the effect of presenting oneself as an object of reflective thought; namely, to reflect on one's self. Secondly, 'self' is understood to refer to a particular kind of experience in which selfhood is located in the 'inside' of an individual. The sense of self is a sense of interiority. Thirdly, Foucault writes about ethical self-formation in terms of a universal human capacity of reflective thought which is taken to be the ground of ethical life. And finally, this particular language of analysis – self-cultivation, self-fashioning, self-creation, self-formation – suggests that we are dealing with a notion of the self which is seen as always in-the-making (cf. Strathern 1995) – always a product, in these ethical terms, of its own 'reflective thought' (and the reflective thought of others). However, this way of talking about 'the self' is not the only way in which 'it' can appear in our anthropological analyses.[123]

[123] Of course, Foucault's influence on anthropological approaches to 'the self' is remarkably diverse and any attempt to characterise this literature collectively as 'Foucauldian' or 'post-Foucauldian' runs the risk of overgeneralisation and might miss out on the specific anthropological critiques of the limitation of Foucault's approach to subjectivity and selfhood voiced by the very same authors who draw on his work. In spite of these hesitations, it seems important to note still that Foucault's theory of self-cultivation is profoundly evocative of psychoanalytic thinking on intersubjectivity and the relational formation of the self (see e.g. Kirshner 1991), especially with regard to the French tradition of psychoanalysis of the same period in which Foucault wrote (see Lacan 1981). It seems that Foucault's own notion of the self, and what it owes to psychoanalysis, has been left largely unexamined. A more general point is that anthropologists have often used Foucault as their conceptual arsenal to deconstruct 'essentialist' concepts associated with psychoanalysis or psychology (see Introduction). However, an anthropological tendency to deconstruct psychoanalytic theories of 'self' – from Malinowski (1927) to Leach (1958) and Lévi-Strauss (1963), through

The enthusiasm for reflective thought has also more recently entered anthropology through a new analytical language borrowed from psychology that centres around the psychological concept of 'metacognition'. Metacognition was a term invented in part to account for an area of study in cognitive development psychology concerned with the ways in which children become aware of their own cognitive abilities in a learning environment. Metacognition is said to have been coined by the development psychologist John Flavell in 1976, although cognitive psychologists of earlier decades, prominent figures such as Piaget, Hart and Vygotsky, have also been credited with the research and ideas leading up to its conception. Flavell's use of the term to describe children's self-reflecting abilities in making certain judgements (such as the ability to evaluate why 2+2 = 4) was rather more specified than the way in which anthropologists have tended to deploy the concept in recent years – in peculiarly more generalised terms whereby 'metacognition' or 'metacognitive' appears to stand for a universal human capacity to reflect on one's own mind or mental activity.

This has been elaborated recently by anthropologists as referring to a capacity to reflect on your own thought processes or thinking about thinking; as a process or practice of observing and relating to one's own cognition; and as reflexive self-consciousness (cf. Luhrmann 2018; Mair 2018; Mair & Cook 2018; Schjødt & Jensen 2018). According to the anthropological theorisation, practitioners of CBT and mindfulness could be said to engage in an explicit practice of metacognition in these terms. Metacognition is here the capacity to become aware of, observe and relate to your thoughts. It is the capacity to be 'meta' – from Greek *meta*, meaning 'after' – in relation to one's own cognition. 'Beyond thinking', we might say.

It is in such a formulation that we might detect similarities with an anthropology of ethics that talks of the ethical subject in cognate terms. Metacognition is here presented as a human capacity that is at once an intrinsic feature of the human mind and a practice that can be 'cultivated'. The higher up the cognitive ladder or diagram, the more into the moral landscape of 'the self' we are seen to tread. Cognition, awareness, attention, and all other perceived workings of 'the mind' are often construed through common metaphors by which they are granted a 'higher-order' status (e.g. clouds/sky). In CBT as in mindfulness, 'cognition' distinguishes a mind in a body distinct from its relations with others or an 'external' world; and vice versa, 'the world' is seen to enter through cognition: through 'internal' and individuated

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Foucault (1961), and onwards – does not automatically render anthropological writings on the 'self' void of essentialism (see e.g. Quinn 2006).

thinking and reflection (see also Chapter 4). Metacognition, as practised in CBT and mindfulness, is thus a concept that stacks the world spatially and vertically. It assumes human cognition in terms of a cognitive hierarchy, a stratum in which cognitive capacities are ordered from the 'lower' to the 'higher'; metacognition refers to what is called 'higher order' thinking in the cognitive sciences. It has also been likened to a form of 'higher consciousness' or 'radical reflexivity' (Cook 2018, citing Taylor 1989: 163; see also Teasdale et al. 2002; Luhrmann 2018; Mair 2018; Mair & Cook 2018); in CBT, this 'higher consciousness' and 'reflexivity' are seen as an effect of the participants learning to evaluate their thoughts as objects of inspection, whereas in mindfulness, such notions hinge on the participants' cultivated ability to observe and then detach from their own cognitive experience.

'Metacognition' involves then a powerful spatial metaphoric that has tended to hold common salience in the theoretical worlds of anthropologists and psychologists alike. Versions of this epistemological and moral topography remain widespread in some areas of anthropology: for example, in how some anthropologists still arrange and conceptualise categories such as 'economics' and 'politics' through to 'culture' and 'cognition'.[124] We tend to find the former two – economics and politics – resting on more solid ontological ground, and they are felt perhaps to be more 'material' or 'real', with the latter – culture and cognition – occupying a realm of abstraction and felt to be more intangible; cognition and culture have their own reality – at least to some anthropologists who write about 'culture' or 'cognition' as gatekeepers of what it really means to be human (see e.g. Bloch 2012; LeVine 2010; Luhrmann et al. 2015).

The concept of metacognition has perhaps become another such organising category in anthropological analyses and can feel as if it is moving us up the moral ladder. Some anthropologists may feel that metacognition has offered an exciting psychological language through which to speak to an anthropology of ethics (cf. Mair & Cook 2018), and it has undoubtedly promised, like the notion of 'culture', another technique of self-knowledge for anthropologists (cf. Strathern 1987).

[124] For various critiques of these categories, see Ardener (2007 [1989]); McDonald (2006; 2012); Toren & Pina-Cabral (2011); Candea (2011).

In the meantime, running away analytically with concepts like metacognition as a meta-category of what it means to be 'ethical' runs the risk of elevating 'reflective thought' (or 'reflexive self-consciousness', 'radical reflexivity', etc.) above other ethnographic concerns.

Care and self-care

Many anthropologists could be said to have fallen in love with Foucault since the 1970s, and for good reasons, when his genealogies of madness, the 'psy' disciplines and power/knowledge brought new insights and concerns to the fore, and many have more recently rekindled their Foucauldian love with the rise of new anthropological orientations towards the 'ethical', 'self-care' and 'the good', also owed, at least in part, to the work of Foucault.[125]

Foucault's positioning of 'the ethical' as intrinsic to the human subject has been particularly instructive to social anthropology in recent years. It is the later work of Foucault concerned with what he called the 'genealogy of ethics' (see Laidlaw 2018) that has yielded new enthusiasms amongst anthropologists. Much of the current anthropological enthusiasm for 'the ethical' and 'subjectivity' is owed to this Foucauldian literature (and to feminist scholarship). 'Ethical self-cultivation' is commonly theorised as the reflexive capacity of human beings to relate to themselves and others; a capacity that allows the individual to imagine and act out a potentiality of self-other relations; and to act upon oneself in a certain way in order to become a certain kind of person (see Laidlaw 2002, 2014; Faubion 2011; Moore 2011).

Important aspects of psychological therapy could thus be understood as constituting a particular kind of 'ethical' process in these terms: the practice of 'psychotherapy' constitutes a progressive positioning of an ability and willingness to imagine, learn, and act on new self-other relations, with the instantiation of the 'therapeutic relationship' itself requiring an ethical engagement on the part of both therapist and patient; there have certainly been suggestions of this in earlier analyses (see Bruun 2013).

However, there are important limitations to this kind of theorisation in that it shares a language with its objects of analysis. Psychological therapies or the 'psychotherapeutic' share in a language of ethical self-cultivation. A language of 'care' and 'self-care' derived from an anthropology of ethics can persuasively move us away from governmental accounts of

[125] See e.g. Faubion (2011); Laidlaw (2014); Mair & Evans (2015); Mattingly & Throop (2018); Moore (2011); Robbins (2013).

psychological realities and also allow us to appreciate the 'openness' (Vogel 2016) of reflecting and acting upon one's self – theories of ethical self-cultivation reframe the language of 'intervention' as a practice of (self-)care.

The language of care and self-care that has now been appropriated in both anthropology and psychology has wrought new realities for both. Psychological therapies construed as *interventions* have been felt by some anthropologists to be 'cold' (Pols 2012) – scientifically detached, impersonal, and instrumental – as opposed to the 'warm' qualities that clinical practices might also be seen to involve, such as alleviating pain, removing a cancerous tumour, washing a dead body; listening, understanding, respecting, engaging, and indeed 'intervening' – in bodies, minds, tissues, cells, and thoughts. This shift from cold to warm is what Annemarie Mol and others have described as attending to 'good care' or 'the logic of care' (Mol 2008): it has meant new attention to the 'persistent tinkering in a world full of complex ambivalence and shifting tensions' (Mol et al. 2010: 14).

When studying psychological therapies, anthropology can very easily slip into the same assumptions that therapies like CBT and mindfulness rest and rely on: assumptions about what counts as 'scientific evidence' and 'good care', for example. We as anthropologists might too easily (and unintentionally) proceed in our own professional analyses by taking for granted cherished notions and values that we hold about ourselves and the world in which we live in – and we might well share some of these ideas with the psychotherapists I studied – be it the ostensible realness and virtue of 'wellbeing', 'self-care', or indeed a sense of 'self', 'cognition', 'the human mind', and so forth. This thesis has attempted to proceed without taking these ideas – and the authenticity and virtue we might ascribe to them – for granted.

Doing anthropological research on mental healthcare will usually involve working your way through ever more technical and specialised publications from the cognitive sciences. It can be difficult, even for the anthropologist, not to be persuaded by the intricacy and mastery of research methodologies, for example, or more simply the density and seeming conclusiveness of diagrams, statistics, and experiments, through which a scientific discipline such as psychology operates and produces its scientificity.

The historical relationship between the disciplines of anthropology and psychology serves as a case in point here (Hickman 2010; Moore 2007; Toren 2012a). Anthropology and psychology can be seen to have produced their own interdisciplinary fields, from cognitive

anthropology in Britain (Frake & Tyler 1987) to psychological anthropology in America (Schwartz et al. 1992), both of which have become influential in anthropology more broadly. More recent anthropologies continue to be largely forged in the epistemic world of the cognitive sciences on both sides of the Atlantic, albeit in obviously very different ways.[126] Psychological anthropology and anthropological studies of 'psy' disciplines have not always departed in their claims and assumptions from those found in the therapeutic realities that they had set out to study and write about. Few anthropological studies have allowed themselves to treat psychological worlds ethnographically in a way that means not only describing the knowledge claims of the people studied but also interrogating the very assumptions that underlie psychological epistemologies, and through which knowledge claims of various kinds come to seem so axiomatically reasonable or real.

I have tried to avoid theorising 'the self' prior to analysis in order to let it appear ethnographically. The advantage of an analytical suspension of our own presuppositions about what the 'the self' might mean is that it elucidates how we construe ethnographic objects of enquiry in the first place whilst avoiding, more rigorously, ethnocentric theorisation.

I have suggested that 'reflective thought' and 'metacognition' might not be unproblematic concepts in our anthropological analyses, and that the enthusiasm for both is ethnographically interesting. CBT and mindfulness, as well as anthropological theories of ethical self-cultivation, have all participated in shaping an ethnographically interesting being that both CBT and mindfulness require: an individuated mind-in-a-body composed of reflective thought; a 'self' capable of rendering itself into an object of care and intervention. It is also a self that seems to emerge as a kind of cognitive cultivator. 'The self' is objectified as a project of self-care.

These cherished notions of selfhood located in a universal human capacity of reflective thought, presently salient in both psychological and anthropological worlds, share in the persuasions of an earlier psychology that sought to rescue 'subjectivity' from the elusive universe of what it means to be human.

[126] See e.g. Biehl et al. (2007), on 'subjectivity'; Bloch (2012), on 'cognition' and 'human nature'; Luhrmann & Marrow (2016), on 'schizophrenia'; McKearney & Zoanni (2018), on 'the self'.

conclusion

This thesis has presented an ethnographic insight into evidence-based psychological therapy in the institutionalised form it is now taking in the United Kingdom. It has attempted to throw ethnographic light on some of the effects of this institutionalisation and the scientific persuasions that have made it possible.

Chapter 1 opened with a therapist's reflections on what she felt was the problem of psychological therapy as it had been constituted and provided within the medical model of the IAPT service: IAPT did not leave a lot of space, we were told, for people to be 'contradictory' and 'complex' human beings. We saw in this first chapter how practices of 'improving access' to IAPT in a community centre in South London unfolded in the daily work of mental health professionals, volunteers, and residents to encompass and enact other forms of therapeutic care beyond IAPT's '(bio)medical' model of psychological provision and intervention. Contradiction and complexity abound. The case of the community centre and its efforts to improve mental health and wellbeing exemplified how there might be limitations to how we approach, think about, and situate the effects of the IAPT programme specifically (and mental healthcare services in general) along the conceptual division and contestations of medicalisation/de-medicalisation as frameworks or explanations of the 'psychotherapeutic' and the 'biomedical'. We were reminded, with some therapists themselves yearning for the 'relationship' in psychotherapy, of the inherent relationality of 'care'.

Chapter 2 offered some historical reflections on 'mental healthcare' in Britain in the context of considering some key historiographical moments in the written histories of psycho-therapeutics. These histories provided an important backdrop against which we then turned to the invention of the IAPT programme and the ideals and concerns through which it was forged. I argued that particular economic arguments grounded in 'happiness economics' were the driving motor behind the 2008 instigation of IAPT as a nationwide public mental health service. I suggested that IAPT was designed as a joint 'psychological-economic' enterprise through its founders' – the psychologist David Clark and the economist Richard Layard – reconstruction and mobilisation of the category of 'depression', combining at once therapeutic and economic objectives.

Chapter 3 took us into the institutional context of IAPT and the model and monitoring of IAPT itself. It then described and examined some common critiques of IAPT and psychological

therapy and the significance of such critiques for anthropological analysis. I argued that Foucauldian theories have tended to shape the anthropological imagination and the study of 'psy'; that anthropological critiques and contextualisations might not always differ greatly from those found amongst the people under study; and that we are witnessing, in another area of social anthropology once again, a theoretical shift from 'governmentality' to 'freedom'; from 'self-governance' to 'self-care'.

Chapter 4 brought us to an IAPT-accredited university course in Northern England where we followed some aspects of the education and training of CBT therapists. The chapter explored how students of CBT learn to be 'therapeutic' through a dynamic process of acquiring bodies through which new affordances can also be constructed; bodies that are newly sensitive because they have learnt to be affected by all the circumstances that constitute 'Cognitive Behavioural Therapy'. I argued that learning to work therapeutically is at once a corporeal and conceptual engagement as students learn through a simultaneity of theory and practice, moving between different 'working objects' from manuals to diagrams, patient cases and questionnaires, including categories of illness and care, over the course of their training. In doing so, this chapter attempted to move anthropology beyond an analytical overemphasis on 'narrative' and 'emplotment' – even in ethnographic contexts of '*talking* therapy'.

Chapter 5 invited us to the conferences in which evidence-based therapy is discussed amongst professionals, and in which a 'real science' of psychotherapy is self-consciously pursued and defined against a notional 'pseudoscience'. The chapter juxtaposed some historical and contemporary inventions and reinventions of 'objectivity' and looked at how some of these have been transformed through the emergence of 'evidence-based' psychology and its efforts to locate itself in evidence-based medicine (EBM). We saw for example that the practice of 'introspection' as the epistemic bedrock of psychology has long posed problems for the discipline's ambitions to achieve an objective status on an equal footing with medicine. Consequently, the human 'subjectivity' deemed at the heart of psychotherapy has been required to be constituted as a stable object of scientific observation. A version of this scientificity could be said to have been finally achieved with the recognition of IAPT therapies as 'evidence-based', but it is also because of this achievement that empirical tensions have continued to loom large.

Chapter 6 explored the models of selfhood that evidence-based psychological therapy 'invites' its subjects to engage with and how such subjects are tacitly cast in the process. This chapter described and examined the therapeutic specificities of psychological therapy as we

moved from CBT to mindfulness. By comparing CBT and mindfulness, I argued that whilst they have become recognised as effective interventions for a range of mental health problems within the framework of IAPT, they have also generated their own therapeutic uncertainties. Psychological therapies have come to shape conflicting models of 'mind', with different notions of selfhood effected through these practices.

I have tried to show throughout the thesis that the invention of the IAPT programme in its nationwide implementation as part of the NHS was a self-defined 'scientific' strategy informed by both clinical need and economic cost-effectiveness to promote evidence-based psychological therapy. This entailed most significantly a formulation and promotion of CBT as the hallmark of a psychological intervention science. I have argued that the reported 'success' of CBT, including the provision and proliferation of evidence-based psychological therapies in general, has been largely achieved within the frame and shadow of EBM in its striving to gain scientific recognition on an equal footing with psychopharmacology. Evidence-based practice defines evidence, we have seen, as that which has been produced through the use of randomised control trials, with this experimental method relying on specific modes of objectification, standardisation, and quantification. These trials offer the 'evidence' on which psychological therapies are seen ideally to be 'based' – through their citation – and are crucial to those therapies' enactment. Psychology's pursuit of scientific objectivity, its citation and production or reproduction of evidence in conferences, journals and professional training, has required psychological therapy to be transformed into an object of science, with 'subjectivity' at its core. I have attempted to show that such an ambition is not new in psychology – that is, it is not a new ambition that has appeared with IAPT – but is a longstanding preoccupation. Rather, scientific persuasions of this kind have been given new life, and generated new tensions, with the invention of IAPT.

My research has also shown that key to the IAPT service are the structural constraints of limited NHS resources: that mental health professionals report inadequate short-term training at the lowest levels of the professional hierarchy (i.e., Psychological Wellbeing Practitioners); that the most treatment-intensive provision of psychological healthcare only consists of 8–12 one-to-one CBT sessions – and often relies too heavily on brief psychological assessments and manualised instructions (or 'psychoeducation') and computerised CBT-based programmes, as IAPT therapists have to be 'outcome'-focussed and 'target'-orientated from the outset of clinical practice.

I have tried to suggest that a productive way of approaching 'evidence-based psychological therapy' calls for a keener ethnographic treatment of psychological epistemologies. In shifting the analytical focus away from an exclusively genealogical examination of 'psy' and its institutions – including structuring theories of governmentality, on the one hand, and ethical self-cultivation, on the other – I have drawn attention to the practitioners' own accounts of the IAPT service and their experiences and understandings of their own work.

One important aspect of my approach has been to take a deliberate step back from common analytical categories found in both psychology and anthropology, as I detailed in the Introduction. I have in other words sought to avoid taking for granted some cherished assumptions about the human subject and its perceived interiority that are found in the analytical toolkits of both disciplines. This thesis has instead attempted to look at why we (anthropologists and psychologists alike) might find certain ideas – for example, cognition construed as a reflective capacity pertaining to a cultivating self or the practice of introspection and observation or the notion of evidence – so compelling and indispensable. This is not an easy task, of course. It is not easy to interrogate psychological theories that mental health professionals might hold about themselves and others and the world in which they work; and far less easy to hold some of those same prevailing ideas in my own professional discipline up for ethnographic inspection. It is not an easy task, nor is it always well-received.

Consequently, I have suggested that it is no longer our anthropological task to say this or that is or is not wellbeing and mental health, or to point to 'the mind', 'subjectivity' or '(meta)cognition' as a locus of anthropological insight. Instead, these concepts are dispensed with analytically so that they can be studied as part of how people might constitute, reject or live them; how they might understand any of these notions and engage in the therapeutic realities that have taken shape around them. The direction I have taken in this thesis was also intended, therefore, to help foreground some tacit commitments in anthropology that might not always depart from the persuasions or sensibilities of psychotherapy. Despite the apparent diversity of theoretical orientations in the respective disciplines, the 'interpretive' and 'reflexive' work, for instance, of anthropologists and psychotherapists is remarkably alike – and the resonances are obvious to those who know both (see Luhrmann 1998, 2000, 2019, on this point).[127] Anthropologists have not always been ready to acknowledge such commonality, as I

[127] Anthropology and psychotherapy or clinical psychology have, of course, distinctively different 'objectives', we might say, as psychotherapists are ultimately interested in the therapeutic care of people whilst

have suggested on several occasions throughout the thesis. Increasingly, however, some anthropologists have called for more direct engagement with the psy disciplines and the cognitive sciences.[128] Notwithstanding the merits and ambitions of such (admittedly very different) calls for engagement, this thesis has sought instead to offer a different anthropological engagement through detachment of a kind (Candea et al. 2015); a detachment from common psychological realities in an attempt to contribute to an anthropology *of* psychology.

It is certainly not an easy task to do an anthropology of psychology in these terms: to do an ethnography of people for whom 'mental health' is a universal, if variable, feature of human beings; of people who live this and practise it and for those whose selfhood or professional world takes experiential shape around it. This has not been easy because the ethnographer will consequently have to outline and interrogate certain realities – notions, approaches, theories, actions, etc. – which we as anthropologists may well share and cherish in our own daily lives or intellectual worlds (see McDonald 1986, on this point). Recent anthropological attention to 'metacognition', for example, shows how exceedingly difficult it is to reflect on our division of the universe (to borrow a phrase from Candea 2011), and in turn allow this conceptual world to unfold as the stuff of ethnography.[129] Of course, this very thesis might be seen precisely as a demonstration of psychological 'metacognition' or Foucauldian 'reflective thought', but only so within the same structures of a conceptual world that I have tried to examine here. I hope I have made it clear that such a response would be to miss the point.

The recent enthusiasm for metacognition, for instance, in the fields of both psychotherapy therapy and anthropology is ethnographically interesting in and of itself. Why? Because, as we have seen, theories of metacognition and reflective thought have all helped shape an ethnographically interesting human subject that psychological therapy at once requires,

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anthropologists are not (necessarily); psychotherapists are trying to help people change whereas anthropologists have traditionally imagined themselves as trying to change the people they study as little as possible.

[128] See e.g. Bloch (2012); Khan (2017); Luhrmann et al. (2015); Martin (2019); Throop & Laughlin (2007); Whitehouse (2001). For some critical reviews, see Hickman (2010); Irvine (2018); Toren (2012a). See also introduction and articles in the April 2020 special issue of the JRAI, edited by Tanya Luhrmann (2020) who report on the 'Mind and Spirit' project, a major collaboration between anthropologists and psychologists. This special issue appeared several months after my thesis was submitted and examined, but I want to include a reference to it here since the project speaks to some important theoretical and empirical questions and problems dealt with in this thesis.

[129] This scenario also seems particularly ironic since 'metacognition' is often presented as a form of radical reflexivity.

assumes and confirms: an individuated mind-in-a-body-subject complete with a reflective self-consciousness; capable of rendering an experiential interiority or 'self' into objects of observation, inspection and knowledge in the pursuit of its own perceived 'mental health'.

Lastly, this thesis shares, in its own way, a 'renewed interest more generally in care as a relational quality' (Lynch & Cohn 2016: 534). It is also within such an anthropological concern with 'care' that we might detect some of 'the limits of [our own] relational thinking' (Candea et al. 2015). *The self in relation to itself and others* has long been not only a defining feature of anthropology and, indeed, of psychotherapy, but also the definition of 'care' itself (cf. Foucault 1988c, 1997).[130] This thesis has not always ventured beyond this definitional world, but I hope that it has begun to open up some of the persuasions of such a world for ethnographic reflection.

[130] Different versions and expositions exist in anthropology of such a defining feature of the discipline and its subject-matter, with a focus on, for example, the category of the person (Carrithers et al. 1985), self-other relations (Moore 2007), relations themselves (Strathern 2020), intersubjectivity (Toren 1990), self-formation (Laidlaw 2014), and theory of mind (Luhrmann et al. 2011); to name just a few – the list is long and varied.

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